

# **Unfulfilled Expectations:**

A narrative study of individuals' experiences of being a patient on an acute psychiatric inpatient ward in Scotland

**Rosemary Clare Stenhouse**

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The University of Edinburgh  
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# **Contents**

	<b><u>Page</u></b>
<b>Chapter One: Introduction</b>	<b>2</b>
1.1 A view from somewhere	2
1.1.1 <i>Introduction</i>	2
1.1.2 <i>Personal experience</i>	3
1.1.3 <i>Changing political and ideological climate</i>	4
1.2 Situating the research	6
1.2.1 <i>Research aims</i>	6
1.2.2 <i>Locating the research within the current field of research into acute care</i>	6
1.3 A note on language	9
1.3.1 <i>Patients</i>	9
1.3.2 <i>Research participants</i>	9
1.3.3 <i>Individuals and people</i>	9
1.3.4 <i>Acute ward and acute care</i>	10
1.3.5 <i>Narrative and story</i>	10
1.4 Overview of the chapters in this thesis	10
1.4.1 <i>Chapter Two</i>	10
1.4.2 <i>Chapter Three</i>	11
1.4.3 <i>Chapter Four</i>	12
1.4.4 <i>Chapters Five, Six and Seven</i>	13
1.4.5 <i>Chapter Eight</i>	14
1.4.6 <i>Chapter Nine</i>	14
 <b>Chapter Two: Acute Care</b>	 <b>15</b>
2.1 Introduction	15
2.2 Mental Health Policy in Scotland	16
2.2.1 <i>Introduction</i>	16
2.2.2 <i>Them and us: Social inclusion and mental health policy</i>	17
2.2.3 <i>The Mental Health Act: Balancing risk and treatment</i>	19
2.2.4 <i>The role of acute care in Scottish mental health services</i>	22
2.3 What is acute psychiatric inpatient care like?	23
2.3.1 <i>Introduction</i>	23
2.3.2 <i>The acute inpatient population</i>	25
2.3.3 <i>The ward environment</i>	26
2.3.4 <i>The nurses</i>	29
2.3.5 <i>Patients' experiences of being nursed on the acute ward</i>	38
2.4 Summary	40

<b>Chapter Three: Representing Experience</b>	<b>42</b>
3.1 Introduction	42
3.2 Writing participants' lives	44
3.3 Representing experience as narrative	48
3.3.1 <i>Narrative expression of experience</i>	48
3.3.2 <i>Discourse as context for narrative</i>	51
3.3.3 <i>Situated meanings and discourse models</i>	53
3.3.4 <i>Narrative structure and meaning</i>	56
3.3.5 <i>Narrative knowing</i>	59
3.4 Summary	61
<b>Chapter Four: Researching Experience: Research Design</b>	<b>63</b>
4.1 Introduction	63
4.2 Ethical principles	64
4.2.1 <i>Introduction</i>	64
4.2.2 <i>Voluntary participation</i>	64
4.2.3 <i>Informed consent</i>	65
4.2.4 <i>Anonymity and confidentiality</i>	66
4.2.5 <i>Ethical approval</i>	67
4.3 The research participants: Access, recruitment and sample size	68
4.3.1 <i>The research site: The acute ward</i>	68
4.3.2 <i>Developing an access strategy</i>	70
4.3.3 <i>The role of ward staff in recruiting participants</i>	72
4.3.4 <i>Introducing the study to potential participants</i>	75
4.3.5 <i>Becoming a familiar face on the ward</i>	77
4.3.6 <i>Sample size</i>	78
4.4 Eliciting and gathering narratives: The data collection method and strategy	80
4.4.1 <i>Introduction</i>	80
4.4.2 <i>Unstructured interviews as a data collection method</i>	82
4.4.3 <i>The research relationship</i>	87
4.4.4 <i>The two interview strategy</i>	91
4.4.5 <i>Location of interviews</i>	92
4.5 The search for meaning: Data analysis	94
4.5.1 <i>Introduction</i>	94
4.5.2 <i>Defining the unit of analysis</i>	95
4.5.3 <i>Transcribing interviews</i>	97
4.5.4 <i>Anonymity and the assignment of pseudonyms</i>	101
4.5.5 <i>Analysing the data</i>	102
4.6 Presenting the data	103
4.6.1 <i>Introduction</i>	103
4.6.2 <i>Poetic re-presentations</i>	103
4.6.3 <i>Thematic presentation</i>	105
4.6.4 <i>Limitations in representing the constructed nature of the data</i>	106
4.7 Introduction to the data chapters	107

<b>Chapter Five: Help: Expectations and Experiences</b>	<b>110</b>
5.1 Introduction	110
5.2 Expectations of help as a main influence on decisions to accept admission to the ward	111
5.2.1 <i>Introduction</i>	111
5.2.2 <i>Expectations of help originating from external sources</i>	111
5.2.3 <i>Personal beliefs that admission to the acute ward will help</i>	112
5.2.4 <i>Balancing expectations of help against the negative social impact of admission</i>	114
5.3 Focussing on nurses as the main source of help on the ward	116
5.3.1 <i>Introduction</i>	116
5.3.2 <i>Expecting nurse-initiated interaction as indication of caring attitude</i>	116
5.3.3 <i>“You have to come and find us”: Accessing the nurses for support</i>	117
5.3.4 <i>Personality and illness as a barrier to initiating interaction</i>	118
5.3.5 <i>Nurses were too busy</i>	119
5.4 Evaluating their stay on the acute ward	124
5.4.1 <i>“It was a disappointment...”: Participants’ expectations of help are not met</i>	124
5.4.2 <i>“Time out”: A helpful aspect of being on the ward</i>	125
5.5 “We did more counselling of ourselves...”: Participants supporting each other	126
5.5.1 <i>Introduction</i>	126
5.5.2 <i>Filling the void: Participants’ responses to the Perceived lack of available help on the ward</i>	126
5.5.3 <i>“I felt it was beneficial...”</i>	127
5.5.4 <i>Mutual support: Not beneficial for all</i>	128
5.6 Summary	133
5.7 Discussion	134

<b>Chapter Six: Safe Inside These Four Walls?</b>	<b>139</b>
6.1 Introduction	139
6.2 “You’re safe enough in here”: Expecting to be safe on the ward	140
6.2.1 <i>Introduction</i>	140
6.2.2 <i>Protected from the outside world</i>	140
6.2.3 <i>Safe from themselves</i>	142
6.2.4 <i>“You don’t know what anybody’s in for”</i>	144
6.3 “That’s your job”: Expecting the nurses to keep patients safe	146
6.3.1 <i>Introduction</i>	146
6.3.2 <i>“There is a secure unit for violent patients”: Evaluating the nurses’ response to aggressive incidents</i>	146

6.3.3	<i>“You should have seen...”: Expecting nurses to act on their observations to prevent incidents from occurring</i>	148
6.4	“I was always glad there was a male on”: Participants’ perceptions of male and female nurses’ ability to keep them safe	150
6.5	Participants protecting themselves	153
6.5.1	<i>Introduction</i>	153
6.5.2	<i>Relying on relationships with other patients to stay safe</i>	153
6.5.3	<i>Taking refuge</i>	154
6.6	Summary	155
6.7	Discussion	156
<b>Chapter Seven: Participants’ Experiences of Power on the Acute Ward</b>		<b>162</b>
7.1	Introduction	162
7.2	Participants’ conceptualisation of the hierarchy of power relations on the ward	162
7.3	The psychiatrist’s power over admission and discharge	165
7.3.1	<i>Power over admission</i>	165
7.3.2	<i>Power over discharge</i>	166
7.3.3	<i>Discharge and voluntary status</i>	168
7.4	Nurses’ observations and reports as the basis for the medical team’s decision making	169
7.4.1	<i>“They observe you 24/7”: Experiences of being constantly observed</i>	169
7.4.2	<i>The impact of being observed on participant behaviour</i>	171
7.4.3	<i>Can reports based on observation tell the whole story?</i>	176
7.5	Us and Them: Tension between ward staff and patients	177
7.5.1	<i>Tension arising from frustration at the lack of help received</i>	177
7.5.2	<i>Tension created when participants feel they are not believed</i>	180
7.5.3	<i>Participants’ response to the experience of us and them</i>	182
7.6	Summary	183
7.7	Discussion	185
<b>Chapter Eight: Holistic Poetic Re-presentation of Participants’ Narratives</b>		<b>189</b>
8.1	Introduction	189
8.2	Robert’s story	190
8.3	Jennie’s story	192
8.4	Becky’s story	194
8.5	Peter’s story	196
8.6	John’s story	198
8.7	Amanda’s story	200
8.8	James’ story	203
8.9	Cathy’s story	206
8.10	Jill’s story	209
8.11	Joanne’s story	212
8.12	Josie’s story	214
8.13	Ewan’s story	216
8.14	Connor’s story	218

<b>Chapter Nine: Conclusions</b>	<b>220</b>
9.1 Introduction	220
9.2 What is the experience of being a patient on the acute psychiatric inpatient ward?	221
9.2.1 <i>Introduction</i>	221
9.2.2 <i>Help</i>	221
9.2.3 <i>Safety</i>	223
9.2.4 <i>Power</i>	225
9.2.5 <i>Unfulfilled expectations: Experiencing dissonance</i>	227
9.2.6 <i>The myth of the nurse-patient relationship</i>	228
9.2.7 <i>Participants as strategists</i>	232
9.3 Methodological conclusions	234
9.3.1 <i>Introduction</i>	234
9.3.2 <i>Data collection</i>	234
9.3.3 <i>Access and recruitment</i>	235
9.3.4 <i>Data analysis</i>	236
9.3.5 <i>Presentation of the data</i>	237
9.4 Implications of the findings and contributions to the field of knowledge	237
9.4.1 <i>Introduction</i>	237
9.4.2 <i>Implications for nursing practice</i>	238
9.4.3 <i>Contributions to the field of acute care research</i>	240
9.5 Limitations	241
9.6 Recommendations for future research	243
9.7 Summary	243
<b>References</b>	<b>245</b>
<b>Appendices</b>	
Appendix 1: The values base for mental health nursing	260
Appendix 2: Information leaflet for ward staff	261
Appendix 3: Information leaflet for participants	266
Appendix 4: Consent form	270
Appendix 5: Example of summary transcript	271
Appendix 6: Example of re-transcription using Gee's theories	273
Appendix 7: Example of focus material	276
Appendix 8: Example of analytic notes	277
<b>Tables and Figures</b>	
Figure 3.1 Levels of representation in the research process	43
Figure 4.3 Diagrammatic representation of the process of accessing and recruiting the research participants	79
Figure 4.4 Summary of the data collection strategy	81
Table 3.3 Five levels of structure in a narrative text with their contribution to interpretation and how they are formally signalled	56

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## **Declaration**

I declare that the following thesis has been composed by myself, and that the work is my own.

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Rosemary Clare Stenhouse



## **Abstract**

This study examines people's experiences of being a patient on an acute psychiatric inpatient ward in Scotland. Within the existing research base few studies focus on the patient's experience of acute psychiatric inpatient care, and none of these is set in Scotland. Those that do, indicate that the patient experience of acute psychiatric inpatient care is often negative.

The theoretical perspective of this study conceptualises experience as represented in narrative form, thus the data take the form of narratives. Thirteen participants were recruited through the acute ward. Each participant participated in two unstructured interviews focussed on gathering narratives of their experience. Data analysis was holistic, guided by Gee's (1991) socio-linguistic theories. This holistic analysis culminated in the presentation of each participant's narrative in poetic form.

From the holistic analysis I identified three themes - help, safety and power - that were evident in the analyses of all participants' interviews. The theme of help represents participants' expectations that they will receive help on the ward, and their experiences of trying to get this help. Safety represents participants' expectations pertaining to the ward's function in keeping them safe, their experience of threat and strategies to keep safe. The theme of power represents participants' experiences of power relations within the acute ward. I conclude that participants' experiences of being a patient on the ward are characterised by feelings of frustration, concerns about safety, and the perceived need to focus on self-presentation as they attempt to reach their desired goal of discharge.

# 1 Introduction

## 1.1 A view from somewhere

### 1.1.1 Introduction

All research, no matter how objective it may claim to be, is a view from somewhere, from some perspective (Harding, 1998). What counts as a credible research topic is influenced by the political and ideological climate. The questions that form the basis of research are those to which we attach some importance, and we attach importance to them on the basis of our beliefs and values. In turn, these beliefs and values are influenced by the political and ideological discourses that form the social world in which we live. Just as our values and beliefs influence our choice of research topic, so too they influence the approach that we, as researchers, adopt to answer our questions. Research is, therefore, not divorced from the social world in which we live, but is integral to it, both influenced by, and influencing, it in ways in which we, as researchers, are wholly implicated.

I, as researcher, am a part of this research because I am part of the world that I am researching. As part of this world my value-system is influenced by the dominant political and ideological discourses of the time, either supporting or challenging these, and providing the means through which dominant cultural discourses influence the research endeavour. Thus, all aspects of myself become implicated in the research: my values, beliefs, experiences and knowledge. It is for this reason that I write as ‘I’, placing myself fully within the research, taking responsibility for the part I have played.

This thesis is my narrative of the research. As a narrative it is told from a particular perspective with a particular point, influenced by my choices of what to include and exclude. Through this narrative the reader is invited to assess the trustworthiness of the research. Lincoln and Guba (2003) consider the trustworthiness of a piece of research as “*defensible reasoning, plausible alongside some other reality that is known to author and reader*” (275). Thus, the reader makes an assessment of trustworthiness through his or her evaluation of the methodological and interpretive decisions made by the researcher. In order to do this, these decisions must be made visible to the reader through the account of the research. This thesis sets out such

decisions so that the reader can come to his or her own conclusions about its trustworthiness.

In order to evaluate methodological and interpretive decisions it is necessary to know in what context such decisions were made. Much of this context exists as aspects of myself that are made available to my consciousness as I reflect on the research process. Such reflexive activity occurs throughout the research process, and is not achievable merely by listing pertinent qualities at the beginning. This narrative is, therefore, not just a tale of a simple process, but a narrative of intricate relations between the research topic, the research participants, the audience and myself.

As stated above, the choice of, and approach to, a research topic is influenced by our own subjectivity as well as political or ideological discourse. In what follows I make visible my understanding of the beliefs, values, experiences, knowledge, politics and ideologies that influenced this research.

### *1.1.2 Personal Experience*

The roots of this study can be traced back to my experience as a student nurse. My first contact with an acute inpatient psychiatric ward (acute ward) was as a third year nursing student in the early 1990s. My memory of the ward is of a dingy environment needing a lick of paint. The furniture was marked with cigarette burns, and patients sat round the edge of a large sitting room, smoking. The television room next door provided a much more pleasant environment, but you couldn't smoke in there so it was generally empty. The corridor led straight down from the front doors of the ward, past several single rooms, to the nursing office with its glass front to facilitate observation. Outside the nursing office, where the corridor turned at right angles down to the dormitories, were three comfortable chairs, positioned so that the doors and the corridors could be observed. It was here that I spent many hours observing patients, ensuring that I knew where they were, and that they had not left the ward. When not carrying out observations, the nurses would crowd into the office, writing notes or chatting, the closed door separating them from the demands of the patients. Social workers, occupational therapists and psychologists would visit the ward and take some of the patients off for therapy elsewhere in the hospital, effectively

removing any therapeutic role from the nurses and the ward. Other patients spent their days on the ward, smoking, drinking cups of tea, and bickering.

It was an unsettling experience. It called into question my beliefs about the role of the psychiatric nurse as someone who aims to develop a relationship with patients to facilitate recovery. As a student nurse, participating in nursing duties and observing the nursing staff, this ideal seemed impossible to achieve. Firstly, the activities most valued by the system were those relating to the ward's custodial responsibilities under the Mental Health Act, ensuring that patients were kept safe, hence nursing activities revolved around observations. Secondly, the desire to be a member of the staff group placed pressure on individuals to conform to the norms. The nursing staff gathered in the office, and anyone who then went off to talk to patients was not part of that group. I perceived that the desire to conform to the group norms acted as a force that reduced staff members' desire to leave the office and talk to patients. Finally, the responsibility for undertaking therapeutic work had been stripped from the nurses and rested with the occupational therapists, social workers, psychologists and medics. I wondered if other nurses shared my feelings of impotence. And if we, as nurses, were feeling impotent, what was the impact of this on the patient's experience of being on the ward?

Following this, my contact with acute wards was through my work as a Community Psychiatric Nurse (CPN), and other community roles. Within the Community Mental Health Team in which I was a CPN, referrals were often made to the acute ward as a place of last resort, to have patients admitted when it was no longer possible or safe to work with them in the community. The acute ward was perceived as providing a safe house and medication, whilst CPNs perceived themselves as providing individual therapeutic care through non-medical means such as use of counselling skills.

### *1.1.3 Changing political and ideological climate*

Alongside the questions that arose from my experience, are motivations arising from my belief that people with mental health problems are competent witnesses to their own experience, and ought to have a voice. This personal belief has arisen from, and is supported by, the changing ideologies about mental health problems.

By the mid-nineties, innovations such as the Hearing Voices Network and the Thorn Initiative began to change nurses' views of people with mental health problems. These initiatives promoted the idea that people with mental health problems were capable of taking responsibility for their own health and recovery. Nurses were encouraged to listen to patients' experiences of their illness and work with them to identify coping strategies. This represented a radical shift from the prevailing medical model as it began to re-inscribe the relationship between psychiatric nurses and their patients. However, these innovations were occurring in a climate that was increasingly linking mental health problems with violence, and the consequent policy manoeuvres aimed at persuading the public that measures were being taken to keep them safe.

Plummer (1995) states that the political climate of any historic moment opens up or closes down the opportunities for telling or hearing, particular kinds of stories. Over the course of the past decade, a radical shift, within political rhetoric at least, has occurred with the placement of the patient at the centre of the policy development process. Patients have been recognised as credible witnesses to their own experience, and these experiences have been labelled as valuable to policy makers<sup>1</sup>. This shift has allowed research and literature pertaining to the experience of the patient to gain credibility. Thus, the right political climate - valuing people's accounts of their experience as a credible way of knowing - has occurred to allow the researching of people's experience of mental health issues and services.

In summary, the questions informing the development of this study arose from my experience of working both on the acute ward, and in the community. My belief that people with mental health problems are credible witnesses to their own experience is supported, and informed by, current ideology. This ideology is exemplified in the Government's centralisation of the patient voice in policy development, a shift that adds relevance to this study.

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<sup>1</sup> Although ideology and practice do not always cohere, with attempts to include service users, sometimes being experienced as disempowering and demoralising (Rosengard & Laing, 2001; Crepaz-Keay, 1996)

## 1.2 Situating the research

### 1.2.1 Research aims

The study is designed to explore participants' narratives of their experiences in relation to the main research question:

- ❖ *'What is it like to be a patient on an acute psychiatric inpatient ward in Scotland?'*

The focus of the research is on the individual's experience and with this in mind I have designed the study to allow participants to focus on the aspects of that experience that they regard as important.

The research aims to:

- ❖ Offer a space for the voices of people with mental health problems to be heard; representing them through the products of the research.
- ❖ Contribute to an increasing body of research into acute psychiatric inpatient care
- ❖ Influence mental health nursing practice by offering an insight into the patient experience

I consider the contribution that this research makes to the field of acute care in section 1.2.2b.

### 1.2.2 Locating the research within the current field of research into acute care

*1.2.2a The state of current evidence:* Following the advent of community care in the 1990s, the focus of nursing and mental health policy turned toward the development of community-based practice. With the publication of *Acute Problems* (Sainsbury Centre for Mental Health (SCMH), 1998) attention was once again focused on the acute inpatient ward. There followed the publication of several large-scale reports into acute care in England and Wales (Garcia *et al*, 2005; Higgins *et al*, 1999; Ford *et al*, 1998; SNMAC, 1999). These large-scale studies used mainly survey methods, supported by information gained through interviews and visits, and contributed to the development of a broad picture of acute care. With some

exceptions, for example the User Focussed Monitoring developed by the Sainsbury Centre for Mental Health (Rose, 2001), the surveys were developed by professionals. Thus, the findings offered a professional-centric view, focussing on what the professionals deemed to be important.

There also exist a growing number of qualitative studies of acute psychiatric inpatient care. These studies use ethnography, participant observation, survey, and interview methods to gather data from the perspective of nurses, patients, or both. The findings of these studies offer localised knowledge contributions about particular aspects of acute care.

Autobiographical writing provides a further source of information about acute inpatient care. Unlike the studies whose objective is to illuminate the bigger picture, these narrative accounts offer insight into the complexity of experience, adding detail to the picture that is created through other research methods. Whilst published autobiographical accounts often touch on the author's experience of acute care, few are solely accounts of experiences on the acute wards<sup>2</sup>. Reflections on acute inpatient care are often made in the context of writing about general experience (cf. Davies, 1999), or making a particular point about some issue pertaining to mental health services (cf Chamberlin, 1999; Snow, 1999).

All of the large-scale survey research was carried out in England and Wales. Whilst much of this may be relevant to the Scottish context, there are some notable differences between the mental health services in Scotland, and England and Wales (as well as internationally). Firstly, the pattern of acute inpatient care provision in England and Wales is focussed within district general hospitals. In Scotland, the majority of acute inpatient care continues to be provided in specialist psychiatric hospitals, with limited development of psychiatric wards in general hospitals. Secondly, the Scottish and English Mental Health Acts have developed from the basis of different legal principles, and I imagine that this may impact on the experience of those who are detained in hospital. Thus, whilst all of the research material provides insight into what the experience of being a patient in a Scottish acute ward might be,

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<sup>2</sup> For short accounts of experience of inpatient care see Read & Reynolds (2000) *Speaking our minds: An anthology*.

it is possible that there are differences attributable to the different structures of acute care provision and different Mental Health Acts.

*1.2.2b Contribution of this research to the current field:* This study contributes to the field in the following ways:

- ❖ As a small, qualitative study, this research contributes to an existing body of qualitative studies focused on acute care. The findings of this study, by confirming, challenging and building on the findings of other studies contribute to the field of knowledge about acute psychiatric inpatient care.
- ❖ This study focuses on the experiences of people who have been patients on the acute psychiatric inpatient ward. Within the current research literature, there are very few studies (cf. Kilku et al, 2003; Rose, 2001) that examine the experience of acute care solely from the patient's perspective. Cutcliffe et al (2004) argue for the importance of carrying out research that facilitates an understanding of the 'lived experience' of a particular phenomenon (in this case, attempted suicide). They assert that understanding a person's particular experience of a phenomenon, and what it means to them, is necessary for healthcare workers to be able to offer useful interventions.

In this study, the methodology used generates data that gives insight into the participants' experiences of the phenomenon of being a patient on an acute psychiatric inpatient ward. This knowledge can be used by those working on the acute psychiatric inpatient ward to inform their work, facilitating the development of approaches that are helpful to patients.

- ❖ The literature review indicates that there have been few studies of acute care within Scotland, and even fewer studies of the patient experience of acute care within the Scottish context. This study is carried out in the context of Scottish mental health services, and therefore offers a view of acute care in Scotland.
- ❖ This study also makes a methodological contribution to the field of nursing research. The holistic nature of the data analysis, and the basing of the interpretive process on Gee's (1991) socio-linguistic concepts is a novel



approach in nursing research. The development of such an analytic approach makes visible the means by which participants use the structure of their narratives to convey meaning. Knowledge of this approach offers nurse-researchers the opportunity to gain a closer understanding of the intended meaning of their participants.

### **1.3 A note on language**

#### *1.3.1 Patients*

The term *patient* is used when discussing the person who is resident in hospital. The use of the term *patient* is generally associated with the medical model and the imbalance of power that is associated with this. The participants in this study experience an imbalance of power in their relationships with the staff on the ward, thus the term *patient* reflects their experience. Participants also referred to themselves and others on the ward as *patients*.

#### *1.3.2 Research participants*

I shall use the term *research participants*, or *participants*, to refer to those who took part. Other commonly used terminology for those who participate in research is *subject* or *respondent*, both of which imply the passive stance of the researched.

My intent in using the term *participant* is twofold. Firstly, it conveys my ethical commitment to attend to, and make as equal as possible, the power relations within the research relationship. Secondly, as a means of implying my theoretical perspective that narrative production within the interview situation is an active process in which both parties participate (Holstein & Gubrium, 1997).

#### *1.3.3 Individuals and people*

In an attempt to change the relationship between people with mental illness and the mental health services, the terms *service users* and *consumers* are used within texts. However, the term *consumer* implies that there is a choice that can be made between different services, and that the *consumer* has power within the consumer-provider relationship. *Service user* is a term that attempts to neutralise the power dynamics in people's relationships with the mental health services they use. However, the term

defines people by their use of mental health services and in this respect places them at the lower end of the power dynamic between service provider and user. In order to avoid these pitfalls I will use the terms *people* and *individual* to refer to those who use mental health services

#### 1.3.4 *Acute ward and acute care*

In the interests of brevity, I use the term *acute ward* to refer to the acute psychiatric inpatient ward. I refer to acute psychiatric inpatient care as *acute care*.

#### 1.3.5 *Narrative and story*

Despite some authors' definition of story as a specific genre of narrative, I will use the terms *narrative* and *story* interchangeably throughout this thesis

### 1.4 **Overview of the chapters in this thesis**

#### 1.4.1 *Chapter Two*

Chapter Two constitutes a review of the literature pertaining to acute care with the aim of situating the study within the current field of knowledge, and contextualising the study by critically discussing the policy context within which acute care is set. To achieve this purpose two bodies of literature are reviewed: Scottish mental health policy literature, and acute care research literature. Reviewing the Scottish mental health policy literature highlights the attempts of current policy to derail the historic tendency to use mental health services as a means of excluding people with mental health problems from mainstream society. However, attempts to implement policy premised on these ideals occur in a context where people with mental health problems continue to be linked to concepts of aggression and violence. Mental health policy is therefore wrought with tensions created by the desire to include people with mental health problems in mainstream society, and its juxtaposition with the perception of people with mental health problems as posing a risk to the general population.

The review of research literature pertaining to acute care indicates that the experience of acute care is characterised by issues of boredom and patients' perceptions of an absence of therapeutic input from the nurses on the ward. The findings of these studies indicate that patients do not always feel safe, particularly in respect of other

patients' behaviour. Whilst patients note that nurses are often taken up by ward management tasks, studies of nurses confirm these findings. Despite the nurse-patient relationship being cited as the central feature of psychiatric nursing in the theoretical literature, the research literature indicates that this is not always the reality of nursing on the acute wards.

The review of the acute care research literature highlights gaps in current knowledge, and in particular, gaps in knowledge about acute care in Scotland. It also highlights the dissonance between professional and patient perceptions, emphasising the importance of carrying out research that examines the patients' experiences.

#### *1.4.2 Chapter Three*

In Chapter Three I address the theoretical assumptions about the nature of experience and representation that underpin this study. Within this study I conceptualise experience as directly knowable only to the person who has that experience. The conveyance of experience to another involves representation, and this in turn involves interpretation. Within the research process representation occurs at a number of levels, from the process of first attending to a primary experience to that of reading the finished research report (Riessman, 1993). The research process within this study is therefore characterised by issues of representation.

I perceive narratives as the means through which people represent their experiences. Narratives are constructed in the presence of an audience (real or imagined), the narrator's perception of whom will influence what and how they narrate their experience. Narratives are also generated within the web of power relations in which people exist, and are influenced by the discourses to which they have access. These discourses allow the telling of some narratives whilst closing down the telling of others.

As linguistic representations of experience, narratives require interpretation. In this study I treat language as ambiguous, and it's meaning as contextually situated. Thus, how people narrate their experiences is implicated in the meaning that these narratives convey. I use Gee's (2005, 1991, 1986) socio-linguistic work to provide a framework within which to understand the relation of narrative structure and meaning. In his

1991 paper, Gee develops a theoretical framework in which he conceptualises speech as taking poetic form, where intonation and paralinguistic material are clues to the narrator's intended meaning. It is my interpretation of this theoretical paper that guides the analysis of the data collected in this study.

#### *1.4.3 Chapter Four*

The choices and rationale for the research design are the focus of this chapter. These choices are grounded in the theoretical concepts that are introduced in the previous chapter. A qualitative approach was chosen, with narratives, as representations of experience, being the desired data. In order to elicit narratives I chose to use unstructured interviews as the data collection method. The use of unstructured interviews placed the relationship between participant and researcher at the centre of the research. This use of the research relationship as research tool required consideration of issues of subjectivity and their potential to influence the data gathered.

Whilst the research necessitated an application through the NHS research ethics system, requiring a detailed consideration of all potential ethical issues pertaining to the prevention of harm to the participants, in practice, ethical considerations were an intrinsic and continuous part of the research process. Using excerpts from my research journals I reflect on some of the ethical and practical issues that arose whilst carrying out the research.

The data analysis method was underpinned by the concept that language is representative and meaning derived from the context in which words are spoken (see Chapter Three). I therefore chose to analyse the interviews holistically, rather than fragment them. So that I could achieve my aim of allowing the reader to hear the voices of the participants, the presentation of the data was considered to be critical. I experienced a sense of responsibility toward the participants and chose two methods of presenting the findings. First holistically, as poems, allowing me to present my interpretation of each participant's experience. Poems were chosen as they encourage the reader to engage with the material, asking the reader to look at the familiar in new ways. Secondly, I chose to present the data in thematic form. This decision was

again grounded in the desire to present the experiences that were identified across the data set, strengthening the argument formed by the data.

#### *1.4.4 Chapters Five, Six and Seven*

Having analysed the interviews holistically, I identified three themes that ran through the participants' data; these themes were help, safety and power. In Chapter Five I present data relating to participants' narratives about help. Through these narratives participants explicated their expectations that they would receive help from the nurses whilst on the acute ward. They expressed the expectation that this help would take the form of talking with the nurses, experiencing frustration, anger and disappointment when they were unable to access this help. Their narratives highlighted the resourcefulness of the participants who used each other to meet their needs for support.

Participants expected that they would be safe in the acute ward, and in Chapter Six I present data relating to the theme of safety. A sense of safety from the world outside the ward was expressed, however, participants also experienced threat from within the ward. Participants perceived the other patients as a threat because they lacked information about why these patients were in the ward. The nurses were expected to keep them safe, although participants experienced a greater sense of safety when there was a male member of staff on duty. Expecting the nurses to ensure their safety, participants felt vulnerable when the nurses did not deal with aggressive incidents in a way that measured up with their expectations. In response to feeling vulnerable, participants again told of strategies they used to keep themselves safe.

In Chapter Seven I present data relating to participants' experience of power relations on the acute ward. Participants analysed the power structure on the ward, and interacted with the ward staff accordingly. The psychiatrist was perceived as the most powerful, to whom the nurses and other medical staff played a supporting role. Nurses were perceived as being granted power through their observational and reporting activity. The perception that they were being watched, and that these observations were relayed to the psychiatrist impacting on the course of the participant's admission, resulted in participants taking action to control their presentation of self.

#### *1.4.5 Chapter Eight*

Having discussed the thematic aspects of the participants' narratives, in this chapter I present each individual's narratives in poetic form. These poems are the product of my holistic analysis, and therefore represent my interpretation of the participants' intended message. They are presented without preface to allow the reader to engage with them in a way that is meaningful for them.

#### *1.4.6 Chapter Nine*

In this final chapter I draw together the findings of the study, and reflect on the research methods and design. The findings of the study lead to conclusions that the experience of being a patient on the acute ward was characterised by feelings of frustration, concerns about safety, and the need to develop strategies to cope with the their situation. Expectations of help and safety were unfulfilled. Participants experienced the nurses as distant, and powerful agents of the psychiatrist. Central to the participants' experiences was the absence of the nurse-patient relationship in the form that participants had anticipated. Participants perceive the nurse-patient relationship as central to their experience of being on the ward. The unavailability of the nurses, participants' perceptions that the nurses did not protect them, and the perception that the nurses were observing and reporting on them from a distance contributed to a negative perception of the nurse-patient relationship. This provoked the feelings of frustration and disappointment described by participants. These findings have implications for nursing practice, and service development.

Methodological reflections lead to the conclusion that the methodology chosen facilitated the investigation of the research topic. The access and recruitment strategy facilitated development of the research relationship resulting in a low attrition rate. The data collection strategy facilitated the collection of rich data, and enabled participants to prioritise the agenda, allowing them to protect themselves from overdisclosure, and facilitating the discussion of topics that they perceived were important. Using Gee's (1991) theories facilitated a structured approach to data analysis, and in particular to the link between narrative structure and meaning. Presentation of the data in both holistic and thematic form enabled me to present both the individual experience and to highlight the shared nature of some of the experiences narrated by participants.

## **2 Acute Care**

### **2.1 Introduction**

The setting for this study is acute care, a specific aspect of mental health service provision existing in relation with all other aspects of the mental health service. Mental health services are governed by current mental health policy, and this is grounded in current discourses in mental health. The ideological nature of discourses means that they are intrinsically linked to issues of power (Gee, 1990). Thus, mental health policy, through its basis in mental health discourses, is infused with issues of power

In this chapter I examine the literature pertaining to acute care in order to accomplish several aims: to highlight the conflicts evident in Scottish mental health policy; to illuminate the means by which psychiatry is granted power through mental health legislation; and finally, to examine current knowledge about acute care and highlight apparent gaps.

In the first section I focus on the main mental health policies that shape mental health service provision in Scotland. The values underpinning these policies are held in tension with one another. They spontaneously aim to reduce difference and increase tolerance of mental illness, whilst proffering policies based on an assumed link between mental illness and dangerousness.

There is a growing body of research literature pertaining to acute care, and this forms the focus of the second part of this chapter. A number of large-scale reports have been published over the past decade, and these have generally been regarded as highlighting the dismal state of acute care (SCMH, 1998; SNMAC, 1999). Alongside these larger studies, a number of smaller qualitative studies offer a view of acute care from the perspective of both nurse and patient. Research literature explicating both the patient and nurse experience of acute care is considered.

I examine literature pertaining to mental health nursing because mental health nurses constitute the largest proportion of the ward team. Their continuous presence on the ward means that they are the members of the staff team with whom patients have

most contact. Their understanding and experience of their role as nurses is therefore pertinent to the patient experience.

## **2.2 Mental Health Policy in Scotland**

### *2.2.1 Introduction*

Issues of power permeate mental health services, as the role of such services is the management of people identified and labelled as mentally ill. Whilst the history books tell us that the methods of dealing with those labelled as mentally ill has changed with changing ideologies (cf Porter, 2002; Busfield, 1996; Pilgrim & Rogers, 1993), mental health services remain rooted in the ascription of difference, and the management of those so labelled.

The diagnostic process is an exercise in power, as Pilgrim (2005:11) points out,

*“Psychiatric diagnosis is ...a product of psychiatry...While madness, sadness and fear have always existed, as part of the human condition, ‘mental illness’, or ‘mental disorder’ only exist as by-products of psychiatric activity.”*

Thus, psychiatry, through its medicalisation of particular aspects of the “*human condition*”, has become a powerful force in population management. Mental health policies are the means through which such power is made visible.

Attitudes and ideas about mental illness exert influence over the political and legal frameworks within which the provision of mental health services is situated (Hannigan & Cutcliffe, 2002). Current ideas about mental illness are embodied in political rhetoric that emphasises the importance of treating people with mental illness as a valued part of local communities, reducing difference and promoting equality and inclusion (Scottish Executive 2006b; 2003a). However, mental health legislation also functions to protect the public from the perceived danger posed by people with mental illness (Scottish Executive, 2003b). The ideas and attitudes underlying these policies sit in tension with one another: on one hand promoting the person with mental illness as a valuable member of the local community, and on the other hand inscribing difference and risk to the local community.



Mental health services in Scotland operate within the following policy frameworks:

- ❖ *Framework for Mental Health Services in Scotland* (Scottish Office, 1997) (hereafter referred to as ‘the Framework’)
- ❖ *The National Programme for Improving Mental Health and Well-being* (Scottish Executive, 2003a) (hereafter referred to as ‘the National Programme’)
- ❖ *Mental Health (Care and Treatment) (Scotland) Act 2003* (Scottish Executive, 2003b) (hereafter referred to as ‘The Act’)
- ❖ *Delivering for Mental Health* (Scottish Executive, 2006b).

In this section I will discuss issues of social inclusion and de-stigmatisation of mental illness in relation to their inclusion as underpinning values in Scottish mental health policies. In the following section I will illuminate issues of psychiatric power as granted through the Act. Discussion of the Act also illuminates the potential conflicts in attempting to apply the principles of the Act. The final section discusses the role of acute care as defined within Scottish mental health policy.

### 2.2.2 *Them and Us: Social inclusion and mental health policy*

*“Shall we realize (sic) that We and Them are shadows of each other? We are Them to Them as They are Us to Us.”*

Laing, 1967: 83

*“The special situation of the stigmatized is that society tells him (sic) he is a member of the wider group, which means he is a normal human being, but that he is also ‘different’ in some degree, and that it would be foolish to deny this difference.”*

Goffman, 1963: 149

*The National Programme* (Scottish Executive, 2003a) places social inclusion at its centre. Social inclusion aims to break down the barriers between those with mental health problems and the wider community. As such, it can be viewed as indicative of a move to dispel some of the longstanding ideas that those with mental illness are

incompetent, dependent, and have nothing useful to offer society (Angermeyer & Schulze, 2001). The main thrust of social inclusion policy is awareness raising and de-stigmatisation of mental illness.

As part of *The National Programme* (Scottish Executive, 2003a) the ‘See Me’ campaign was developed with the aim of de-stigmatising mental illness. People become stigmatised when their social interactions are defined by their mental illness (Goffman, 1963). By drawing people’s attention to the wider context of people’s lives, this campaign aims to promote the idea that people with a diagnosis of mental illness are ordinary people with lives that cannot be wholly defined by their illness; “*See me, I’m a person*” (Scottish Executive, 2003a).

However, Goffman (1963) states that although wider society tells those who are stigmatised that they are people too, it also states that they should not forget that they are different and make attempts to pass as normal. To this end, wider society is perceived by Goffman as operating in such a manner as to limit the extent to which stigmatised individuals are allowed to achieve normal-ness. Such limitations in the achievement of normal-ness are conceptualised by Goffman (1963) as protecting those who are normal from having to confront the ordinariness of the stigmatised individual. It is through maintaining difference that wider society defines itself as normal; normal is a relative category, definable as such only in the presence of that which is abnormal (Goffman, 1963; Laing, 1967).

In light of Goffman’s (1963) theories, the ideal of de-stigmatisation and social inclusion are in conflict with the social mechanisms that enable wider society to maintain its normal identity. Normal only exists in relation to difference. Without difference there is no normal, and therefore the mechanisms identified by Goffman (1963) operate to limit the ability of the stigmatised person to pass as normal.

However, despite the political rhetoric, stigmatising attitudes are still detectable in recent mental health policy. For example, in a bid to alter the prevailing culture in the acute wards, the authors of *Delivering for Mental Health* make a commitment to develop the role of peer support workers. They state that these “*peer support workers are an example of expert patients, being trained staff who themselves have direct*

*experience of mental illness*” (Scottish Executive, 2006b: 2) and are part of the ward team. On first reading, this statement appears well intentioned, valuing the experience of those with mental illness to the extent that it is envisaged that drawing on such experience can improve the care provided on the ward. However, on examination, other, less laudable, meanings can be inferred. Firstly, the statement implies that only those with experience of mental illness have the ability to understand or recognise that experience, with the effect of distancing such experience from that of ‘normal’ people (here represented by the doctors, nurses and other ward staff). Secondly, implicit within the statement is the suggestion that it is only by being one of Us (professionals) and one of Them (mentally ill) that it is possible to translate Their experience in a manner that is understandable to Us; it is not enough to simply listen to, and hear, patients’ experiences. This disempowers both Us and Them, in that it implies that the experiences of each are not knowable to the other. This statement exemplifies an attitude that the experience of those with mental illness is too distant from our own experience of the world for us to understand without translation by people who inhabit both groups.

The above example from *Delivering for mental health* (Scottish Executive, 2006b) explicates the difficulties in overcoming what, according to Goffman (1963), is a natural group mechanism: the labelling of those who deviate from the norm as abnormal in order for the majority group to succeed in perceiving itself as normal. In its attempts to counter this mechanism, the policy actively creates rather than reduces difference.

### 2.2.3 *The Mental Health Act: balancing risk and treatment*

*“That an individual can be compelled to receive psychiatric treatment affects each in-patient regardless of whether his stay is formal or informal. It is hardly possible to be unaware that you are being cared for within a legal framework which allows for treatment against your will.”*

Campbell, 2000: 59

The Act is the means by which psychiatrists are granted powers to detain and treat persons deemed to be suffering from a diagnosable and treatable mental illness, who

are perceived to pose a risk to self or others. However, the basis upon which detentions are made is questionable in terms of the diagnostic process, and the process of risk assessment.

The diagnosis of mental illness, (if indeed mental illness exists<sup>3</sup>), involves the fitting of a complex picture of social, emotional and psychological issues into a list of symptoms within the diagnostic manuals (Pilgrim, 2005; Kendall, 1975). This diagnostic process is premised upon the belief that mental illness is rooted within the individual (Kendall, 1975). However, the aetiology of mental illness remains contentious (Pilgrim, 2005), and the lack of biological markers so far identified lends itself just as well to social theories of mental illness. The lack of biological markers, and the very nature of the diagnostic process whereby the complexity of an individual's life is reduced to a list of symptoms, leads to diagnosis resting on the judgement of the psychiatrist (Kendall, 1975).

The process of making a judgement is also at the root of risk assessment. Whilst judgements about risk are based on a variety of sources of information, they nevertheless represent a guess about the likelihood of an individual carrying out an activity that will put themselves or others at risk. Such judgements are influenced by the prevailing discourse about risk and mental illness.

Since the implementation of community care there have been a number of homicides involving people with diagnosed mental illness. The effect of such incidents, often highly publicised, is that they increase the public's sense of vulnerability to those with mental illness, and decrease confidence in the mental health system (Laurance, 2003). Those with mental illness feel stigmatised by the portrayal of people with mental illness as unpredictable and dangerous (Anderson, 2003; Angermeyer & Schulze, 2001). The reaction of policy makers reinforces this link, as protection of the public becomes the focus of mental health policy (Laurance, 2003; Hannigan & Cutcliffe, 2002). Keen (2003: 31) observes:

*“Social policy towards ‘mental illness’ is determined as much by cost and fear of tomorrow’s editorials as it is by compassion. These priorities have led to a pre-eminent emphasis on ‘risk aversion’ and rhetoric of ‘public safety’ and*

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<sup>3</sup> See Sasz, T. (1972) *The myth of mental illness*.

*professionally determined 'best interests' for those deemed most volatile and behaviourally unpredictable..."*

The influence of such attention to risk and the need for public protection can be perceived as the reason for the inclusion of the Compulsory Treatment Order (CTO) in the recent Scottish review of mental health legislation, the *Mental Health (Care and Treatment) (Scotland) Act 2003*. Subjected to the restrictions of the CTO, the individual lives a carefully monitored life, always subject to the power of the mental health system.

Thus, the Act provides the means through which psychiatry manages risk. However, the *Mental Health (Care and Treatment) (Scotland) Act 2003* (Scottish Executive, 2003b), unlike its predecessors, is based upon a number of principles designed to uphold the application of human rights legislation to the situation of those with mental health problems. The main principles are reciprocity, benefit, and participation (McCollam, 2005; Millan, 2001), and are defined as follows:

*"Reciprocity: where society imposes an obligation on an individual to comply with a programme of treatment of care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.*

*Benefit: any intervention under the Act should be likely to produce for the service user a benefit that cannot reasonably be achieved other than by the intervention*

*Participation: Service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of their past and present wishes, so far as they can be ascertained. Service users should be provided with all the information and support necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood."*

Millan, 2001: 6

These principles aim to ensure that where the psychiatric system detains a person in hospital, removing their liberty, it provides them with a service that could not be gained without so doing. However, one might wonder who makes the judgement regarding the extent to which these principles are upheld; the individual to whom the

Act is applied, or those representing the system? Available resources limit the extent to which these principles are capable of being supported; entitlement to a service does not mean that it will be received if the hospital has no capacity to offer it. Thus, whilst these principles are aimed at improving the ethical basis of detention, in practice their achievement is linked to available resources.

In summary, the Act is the means through which psychiatry's power becomes visible, validating the detention and compulsory treatment of individuals on the basis of social judgements about diagnosis and risk. However, the Act also holds promises of help, of service provision in exchange for liberty, balancing the need to manage risk with the need to offer help. As highlighted by Campbell (2000) at the beginning of this section, the knowledge that the psychiatrist has these powers has an impact on the experience of patients regardless of whether they are detained under the Act.

#### *2.2.4 The role of acute care in Scottish mental health services*

Within the Scottish policy framework, the two main documents setting out the shape of service provision are the *Framework for Mental Health Services in Scotland* (Scottish Office, 1997) and *Delivering for Mental Health* (Scottish Executive, 2006b). The Framework focuses primarily on public health and community provision. The role of acute inpatient psychiatric care is not defined, but is mentioned as one of the treatment options for those suffering a psychiatric emergency or acute exacerbation of their problems:

*“An acute psychiatric emergency is when an individual's behaviour or distress requires an immediate response because of the risk of harm to self or others. This may include in-patient admission for assessment, with high levels of supervision and observation and intense medical and therapeutic input.”*

(Scottish Office, 1997: 45)

The trigger for admission to acute care within this statement is the assessment that the individual poses a risk to self or others. This concurs with Bower's (2005) identification of dangerousness as one of the main reasons for admission to the acute ward during his review of the literature pertaining to reasons for admission to acute wards in England. In *Delivering for mental health* (Scottish Executive, 2006b), risk management remains the rationale for admission to the acute ward:

*“The functions of an acute admission ward are to provide support and treatment in an acute phase of illness when it is no longer possible to provide safe effective care in the community.”*

(Scottish Executive, 2006b: 10)

By indicating that it is in response to the perception of risk that admission will be sought, these definitions place risk management as central to the role of the acute ward. Thus, the role of acute inpatient services appears to be one of response to, and containment of, crises (Pilgrim, 2005) that cannot be safely or adequately dealt with in a community setting.

Whilst the role of the acute ward is defined in relation to risk, its function is defined in terms of providing support and therapeutic input (Scottish Office, 1997; Scottish Executive, 2006b). Both definitions refer to the supportive function of the acute ward, yet if the role of the ward is risk management, then part of its function must be related to controlling risk. The specific responses of observation and supervision mentioned in the Framework are geared toward controlling risk. Whilst these might be experienced as supportive by the patient, they can also be experienced as intrusive and distancing (Fletcher, 1999; Dodds & Bowles, 2001; Bray, 1999). Thus there is potential conflict between the acute ward’s risk management and supportive functions.

## **2.3 What Is Acute Psychiatric Inpatient Care Like?**

### *2.3.1 Introduction*

The literature reviewed in this section is drawn from research reports and published autobiographical writing of people with mental health problems. A number of large survey research reports were located (SCMH, 1998; Garcia et al, 2005; SNMAC, 1999; Higgins et al, 1999; Ford et al, 1998). These reported on the state of acute care in England and Wales using survey methods, gathering quantitative and qualitative data. For the most part, the methodologies used resulted in these reports offering a broad overview of the state of acute care in England and Wales. Only two (Higgins et al, 1999; SCMh, 1998) used interviews with patients to gather qualitative information about their experience.

A more specific picture of what it is like to be a patient on the acute ward is gained from examining a body of qualitative research. These small, qualitative studies focus on specific areas of acute care such as nurse-patient relationships (cf. Moyles, 2003; Cleary *et al.*, 1999a; Cleary & Edwards, 1999; Coatsworth-Puspoky *et al.*, 2006; Breeze & Repper, 1998; Altschul, 1972); observations (Fletcher, 1999; Dodds & Bowles, 2001; Kettles *et al.*, 2004); ward environment (Rossberg & Friis, 2004; Andes & Shattell, 2006); safety (Quirk *et al.*, 2004; Sun *et al.*, 2006); and nursing activity (Whittington & McLaughlin, 2000; Bee *et al.*, 2006; Bray, 1999). A variety of methods are used including, participant observation or ethnography, and interviews. Rossberg and Friis (2004) however, used a standardised tool to measure satisfaction with ward environment. These studies represent both nurse and patient perspectives, with Coatsworth-Puspoky (2006), Quirk *et al.* (2004), and Moyles (2003) representing the patient perspective only.

Autobiographical writing is also a source of information about the experience of being a patient on the acute ward. Many of those who have published this type of work refer to spending time in an acute ward at some point in their psychiatric career. These writings offer personal insights into the experience. However, whilst the experiences of these authors resonate with the findings of other studies, their experiences of acute care often took place some time ago, and therefore the accounts are ones of experience gained during a period when different philosophies of mental illness and mental health care prevailed (cf Chamberlin, 1999; Davies, 1999).

All but two of the studies upon which I draw in this section are from an international source; Altschul's (1972)<sup>4</sup> study, and Kettles *et al.* (2004) are both Scottish studies. Many are reports of English studies, although studies from the USA, Taiwan and Australia are included. It is noteworthy that, despite the different mental health systems in which these studies are carried out, the findings are generally congruent, leading to the sense that there is a great deal of commonality of experience across international mental health systems.

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<sup>4</sup> Despite Altschul's (1972) study having taken place over thirty-five years ago, the findings still resonate with those of more current studies of acute care.



Drawing on these resources I will examine the state of current knowledge about acute care with reference to the following aspects:

- ❖ Inpatient population
- ❖ Ward environment – particularly safety and occupation
- ❖ Nurse-patient relationships.

### *2.3.2 The acute inpatient population*

The literature indicates that the experience of being a patient on the acute ward is influenced by the presence of the other patients. At times, the diagnostic mix and acuteness of patients' symptoms can create tensions (Quirk & Lelliot, 2001). Data from the large surveys (SCMH, 1998; Garcia *et al*, 2005) creates the following picture of the acute population in England and Wales. Scottish comparables are offered where obtainable.

*2.3.2a Bed occupancy:* Findings indicated average bed occupancy rates of 93% (SCMH, 1998) and 100% (Garcia *et al*, 2005). These are consistent with Scottish figures (Mental Welfare Commission, 2004). This indicates a situation where there is pressure on beds, with areas utilising the beds of those on leave for new admissions (Faulkner, 1998; Ford *et al*, 1998; Clarke & Flannagan, 2003). The situation is compounded by patients becoming stuck on acute wards because of a lack of adequate resources within the community to support them following discharge from hospital (Clarke & Flannagan, 2003; SCMH, 1998). Thus, the acute ward finds itself catering for both the acutely ill, and those who are well enough to leave but unable to do so because of inadequate resources.

*2.3.2b Legal status of patients:* Reported levels of detention under the Mental Health Act (1983) were found to vary between 15% and 88% (Higgins *et al*, 1999; Ford *et al*, 1998; SCMH, 1998). However, there was no comparison with previous years in order to determine whether these rates had increased.

Scottish statistics indicate that the proportion of all admissions occurring under the Mental Health (Scotland) Act 1984 increased each year between 1998 and 2001 (ISD, 2005). This rise may be related to a number of factors. Firstly, the policy to treat

people in the community for as long as possible, resulting in increased levels of acuteness on admission (DoH, 1999; Quirk & Lelliott, 2001). The authors of *Acute Problems* (SCMH, 1998) attribute the increased sense of threat reported by patients on the wards in deprived areas to increased acuteness of patients' illness as indicated by the inflated number of patients detained under the Mental Health Act (SCMH, 1998). The increased number of patients with co-occurring substance use and mental health problems and the resulting propensity for violence and aggression (Quirk & Lelliott, 2001), may also be partly responsible.

Whilst statistics indicate high numbers of patients being detained on acute wards under the Act, for those who are officially designated 'voluntary' status this may simply represent a difference in levels of compliance. Campbell (2000) and Pilgrim (2005) both argue that regardless of 'voluntary' status, all patients are aware of the potential for compulsion to be applied by those in the position of providing care. The threat of compulsion may be utilised as a means of coercing patients into complying with treatment (Baker, 2002; Scottish Association for Mental Health, 2004; Campbell, 1996). As Sorgaard (2007) observes, a patient's legal status is a "*poor proxy for experienced coercion*" (217).

*2.3.2c Diagnostic mix of patients:* Both Garcia *et al* (2005) and the SCMH (1998) reported that around half of those resident on the acute wards surveyed had diagnoses of non-psychotic mental illness (mainly mood disorders); those with psychotic diagnoses constituted approximately one third of the acute in-patient population.

Whilst it is useful to get a broad overview of the inpatient population, it is worth noting that the studies amalgamate figures from rural and city sites, thus the specific picture in each may differ. The research site in this study is situated within an urban/rural area and could therefore be expected that the inpatient population, and particular pressure on beds, will differ from that in a city site.

### *2.3.3 The ward environment*

Whilst patients, people may spend a lot of time in the confines of the ward. The ward environment therefore has the potential to influence their experience.

*2.3.3a The physical environment:* Patients noted the poor decorative state, and lack of cleanliness, of the acute wards in a number of studies (SCMH, 1998; Rose 2001; Rogers et al, 1993). They also reported a lack of quiet areas on the acute wards (Higgins et al, 1999; SCMH, 1998), and lack of privacy (Rose, 2001; SCMH, 1998). In contrast to the responses of patients, 78% of the ward managers whose opinions were sought in the *Acute Care 2004* study believed that the ward environment promoted “*positive mental health for service users*” (Garcia et al, 2005: 103). The dissonance between staff and patients’ perceptions supports the need to focus on patient perceptions, and not just that of ward staff.

*2.3.3b Ward atmosphere:* The ward atmosphere was found to be important to patients in a study by Rossberg and Friis (2004). They examined 640 staff’s and 424 patients’ perceptions of the ward atmosphere on forty-two wards, some of which were non-acute, using two validated measures. The ward atmosphere scale measured perceptions of aspects of the ward such as involvement, support, autonomy, angry and aggressive behaviour, and staff response to expressed feelings. Findings indicated that the ward atmosphere was more important for patient satisfaction than staff satisfaction. This may reflect the fact that patients have not got the option to leave as nurses do at the end of their shift (Andes & Shattel, 2006; Rossberg & Friis, 2004).

*2.3.3c Ward based activities:* Several studies highlight the lack of activities for patients provided either by nurses or occupational therapists (SCMH, 1998; Walton, 2000; Ford et al, 1998; Shattell, 2007a; Dodds & Bowles, 2001). 30% of patients in the *Acute Problems* (SCMH, 1998) study did not participate in any activity during their stay.

Patients report boredom and the feeling of being left to their own devices (Higgins et al, 1999; SCMH, 1998; Faulkner, 1998; Walton, 2000; Thomas et al, 2002). However, this boredom may have more to do with the quality of relationships that patients have with the nurses than a simple lack of occupation. Binnema (2004) theorises boredom as the patient’s emotional response to his inability to find meaning in the environment. In particular this meaning comes in the form of meaningful relationships and roles on the ward. Patients’ expressions of boredom as the feeling of being left to their own devices, is congruent with the concept that boredom is a

relational concept. Meaningful roles and relationships, according to Binnema (2004), create a sense of control that he contends is a facet of good mental health. Thus, it is Binnema's (2004) contention that through their relationships with patients, nurses could improve patients' sense of meaning and control, facilitating good mental health, and decreasing the experience of boredom.

It is this sense of meaning and control that Bray (1999) seems to be alluding to as she discusses the nurse-patient interactions in the groups she observed during her ethnographic study of nursing on three acute wards. During skills based or social groups such as cooking or beauty groups, the nurses and patients interacted differently to the normal pattern of interaction. Bray (1999) noted high rates of conversation, and laughing and sharing of jokes. The nurses' attitude toward the patients seemed to change, as both gained equal status as they focussed on the purpose of the activities they were jointly undertaking. She concluded that these groups created a space in which patients and nurses could connect, facilitating the development of relationships.

The provision of activities for patients is one of several aspects of the nursing role. In their interviews with nurses, Cleary and Edwards (1999) found that when the ward became busy, the programme of activities was the first to be dropped as nurses concentrated on what was necessary to keep the ward functioning safely. It was the restrictions imposed by a lack of resources that was found by Brennan *et al* (2006) to impinge on the nurses' abilities to provide therapeutic activities. For example, there was no room large enough to hold a group, and not enough comfortable chairs to do so even if there was a room.

*2.3.3d Feeling safe:* The studies indicate that patients experience the acute ward as keeping them safe from the outside world. The feeling that they were safe from everyday problems was reported as a positive aspect of being on the acute ward by nearly one third of participants in the *Acute Problems* study. In their phenomenological study of 8 patients' experiences of life on an acute ward in the USA, Thomas *et al* (2002) found that participants experienced the ward as a place of safety, away from the struggles of daily life. They experienced a sense that they were safe, both from the outside world and from any self-destructive impulses that they might have. These findings are supported by Quirk *et al*'s, (2004) qualitative analysis

of data collected in the national audit of the management of violence and aggression carried out by the Royal College of Psychiatrists in 1999/2000. In their study of nurses' and patients' perceptions of safety on the acute ward in Taiwan in relation to suicide, Sun *et al.* (2006) concluded that being admitted to what they describe as a "*protective environment*" (87) reduced suicidal impulses. In particular the calm and closed nature of the environment was valued by patients.

However, Quirk *et al.* (2004) also found that over the period of a person's admission, this initial feeling of safety diminished as patients recognised the threats that were present in the ward environment; these threats generally took the form of other patients' behaviour. Similarly, several studies report patients' experiences of decreased safety due to the diagnostic mix of patients on the ward (SCMH, 1998; Cutting & Henderson, 2002; Kohen, 2001; Baker, 2002; Sun *et al.*, 2006). In *Acute Problems* the authors report that 9% of patients carried out an assault on either patients or staff with no resulting injury; 5% carried out assaults and caused minor injury. Nearly 33% had non-violent aggressive behaviour reported in their nursing notes during their stay. They conclude that whilst the number of patients perpetrating such behaviours is small, it is conceivable that this type of behaviour raises tension on the wards (SCMH, 1998).

In contrast to the views expressed by patients, Garcia *et al.* (2005) found that 86% of the sample of ward managers in their study stated that they thought their ward was safe for users and staff. This highlights an area of dissonance between patients and staff. If staff perceive as safe an environment which is experienced as threatening by patients, this has implications for the ability of the nurses to provide the patients with the protection they perceive they need.

#### 2.3.4 *The nurses*

2.3.4a *What is mental health nursing?:* Mental health nurses are the most numerous members of the workforce present on the acute ward. Whilst there may be psychiatrists, psychologists, social workers and occupational therapists involved with inpatients, it is the nurses who provide a continual presence on the ward. It is therefore the nurses with whom patients have most contact whilst on the ward. Patients will interact with the nurses on the basis of their understanding of the nurses'

role in the ward. A brief examination of the literature pertaining to mental health nursing offers the reader an overview of how mental health nursing is conceptualised and practised; offering some context within which to hear the participants' narratives.

Today's mental health nurse has evolved from the role of attendant in the asylums. In the asylums, the attendants worked under the direction of the psychiatrists (Nolan, 1993). Much of the work involved the physical control of patients and consequently most of the attendants were male (Porter, 2002). As the provision of psychiatric services evolved, the role of attendant evolved into the role of the mental health nurse.

However, despite ongoing attempts to establish itself as a profession separate from medicine, mental health nursing continues to struggle to define itself. Buchanan-Barker and Barker (2005) refer to the position of the psychiatric nurse in the asylum as the psychiatrist's "handmaiden" (541), bound into a medical framework, supporting the psychiatrist's role and carrying out the care that he prescribed. The publication of Peplau's (1988) vision for psychiatric nursing brought with it the recognition that the nurse's role extended beyond the actions prescribed by psychiatrists. During the struggle to reinvent itself as separate from the medical faculty of psychiatry, psychiatric nursing became known as mental health nursing (Buchanan-Barker & Barker, 2005). However, the proper focus of mental health nursing remains a contentious issue, leading to polarised debate within the literature.

On one side of the debate are those who support the view that mental health nursing should be focussed on the interpersonal relationship between patient and nurse (cf Barker & Buchanan-Barker, 2005; Peplau, 1988; Altschul, 1997; Munro & Baker, 2007). It is the opinion of these authors that the healing capacity of mental health nursing can only be achieved through the relationship that is developed between nurse and patient. The nurse-patient relationship is focussed on what the patient needs, allowing this to guide the nurse in what he or she does (Altschul, 1997; Reynolds & Cormack, 1990; Barker *et al*, 1995). Barker and Whitehill (1997) align this aspect of nursing with craft, where they define craft as the process of creating an object that is

given meaning by the use to which the recipient puts it<sup>5</sup>. Conceptualising mental health nursing in this way places the power to define the meaning of the situation with the patient. It follows, therefore, that to act therapeutically the nurse must attend to the patient's definition of the situation rather than operating from his/her own definition; he or she must get close to the patient's world. The focus of the nurse's actions thus becomes the relationship with the patient. This approach to mental health nursing orients the nurse towards working in partnership with the patient towards a mutual understanding of the problem and agreed plan of care. Roper and Happell (2007: 85) sum up this position as follows:

*“Psychiatric/mental health nursing is premised on the therapeutic relationship as a vital ingredient in facilitating the journey to recovery for consumers.”*

The views held by those on the other side of the debate (Gournay, 2000) are based upon a disease/illness model of mental health that places emphasis on biological aspects of mental illness. Consequently it is technologies that are conceptualised as the nursing response to patients with mental health problems. Randomised controlled trials are the gold standard, facilitating the development of evidence-based practice. Adherence to such evidence-based practice places the nurse in the position of ‘doing to’ patients, where the evidence-base gives the nurse's actions authority.

In 2006 the Scottish Executive report *Rights, Relationships and Recovery: The report of the national review of mental health nursing in Scotland* set out a vision for mental health nursing. The definitions of mental health nursing proposed by this review are congruent with the views of those who see the focus of mental health nursing as the nurse-patient relationship:

*“Mental health nursing is fundamentally about people, about spending time with people, and about developing and sustaining therapeutic relationships with service users and their families and carers.”*

Scottish Executive, 2006a: 14

In order to support the development of mental health nursing in the form described in the above quote, the report proposes the development of values-based practice, and

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<sup>5</sup> Craft is viewed as different to both art and science in that it is the artists and scientists who assign meaning to the products of their labours. Whereas the product of craft is given meaning by the recipient.

sets out the values upon which nursing should be based (see appendix1). Making specific reference to nursing within acute care, the report recognises that:

*“There is a perceived risk that the prevention of untoward incidents and physical harm is becoming the sole focus of the nurse’s role in inpatient care settings.”*

Scottish Executive, 2006a: 24

The report recognises the need to change the focus of nursing within acute care to one that is recognisable as based upon the desired principles for mental health nursing identified by the review. In order to support such change there is an acknowledgement of the need to focus on education, training and workforce issues.

Thus, Scottish Executive policy has incorporated the interpersonal relationship between nurse and patient as the central feature of mental health nursing, proposing that it be based on respect for patients, and the inspiration of hope and recovery. The findings of this review of mental health nursing have an impact on all mental health nurses through the allocation of funding for, and the provision of, education and development. It creates expectation in all stakeholders within the acute care environment that nursing activities will develop in line with those recommended in the review. However, in order to positively change the nursing care provided in acute care, there is a need to provide not only education and training opportunities, but the resources and managerial support, for wards to develop and implement new ways of working.

*2.3.4b Mental health nursing in practice:* In the above section I discussed the theoretical principles of mental health nursing presented in the literature. However, in practice, as was acknowledged within the findings of the review of mental health nursing (Scottish Executive, 2006a), what mental health nurses do is not always congruent with these ideals. Gallop (1997) notes the difficulty of writing about the centrality of the nurse-patient relationship in mental health nursing when it seems that nurses appear to be more interested in paperwork and the giving of advice than listening to patients. Pressure is exerted on nurses by patients and the institution, and their role on the acute ward as described within the research literature is a constant balancing act. It is beyond the remit of this chapter to provide a detailed picture of nursing on the acute ward. However, because nurses have a constant presence on the



wards and their actions have an impact on patients' experiences, I will discuss three aspects of their role: administration of the ward, observations, and therapeutically oriented interactions with patients.

2.3.4bi      *Administration of the ward:* In their study of nursing on five acute wards in England, Clarke and Flanagan (2003) observed that the nurses were expected to undertake a wide variety of tasks, some of which were only loosely connected to patient care. Because of their constant presence on the ward, and the lack of role definition of mental health nursing, the nurses carried out housekeeping, administrative and other duties that became their domain because they were necessary for the smooth running of the ward. Such pressures resulted in them being interrupted when they were with patients in order to attend to the needs of the ward<sup>6</sup>.

The pressure to facilitate the management of the ward may lead to nursing activity becoming routinised. The development of routine nursing activity was conceptualised by Tilley (1995) as a necessary part of making the ward recognisable as such. During each shift the nurses had responsibility for maintaining the ward in a recognisable form, for handover to the following shift. Thus, the performance of ward routine was a necessary part of the management of the ward that enabled its continuation over time. However, in their commentary, Howell and Norman (2000) view routine less as a necessary management tool and more as a refuge for nurses who are failing to develop therapeutic relationships with patients:

*“Failure to work therapeutically at an individual level can lead ultimately to the withdrawal or retreat of nursing staff into routinised activities, and the perpetuation of the worst elements of the system.”*

Howell & Norman, 2000: 607

The literature pertaining to nursing activities within the acute ward indicates that it is activities associated with managing the ward, rather than dealing with the distress/problems of individual patients, that have become the focus of mental health nursing (Radcliffe, 2006; Richards *et al*, 2005; Bee *et al*, 2006). The purpose of such management activities is often based around the reduction of risk (Bee *et al*, 2006).

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<sup>6</sup> See also Cleary and Edwards (1999)

Whilst individual practices such as formal observations<sup>7</sup> appear to be for the benefit of the patient, they are also a response to working in an environment where there is always somebody to be held accountable for whatever happens (Dodds & Bowles, 2001). Thus, risk management is also management of the risk to the individual nurses. Mental health nursing thus focuses on control as nurses try to keep themselves safe in a risk-averse environment by practising defensive nursing.

2.3.4bii      *Observations as control:*      The nurses in Hall's (2004) study described their work in terms of social control functions characterised by observations, restricting patient freedom and managing disturbed behaviour. The nurses in Deacon *et al*'s (2006) study expressed the desire to develop caring relationships with patients, but found that the activities that they were required to carry out were mostly aimed at fulfilling the control function of the acute ward.

Observation is a common response to the need to manage 'at risk' patients. Patients exhibiting acute distress that puts them at risk of harm to self or others are placed on observations by the medical staff. It is, however, the responsibility of the nurses to carry through these observations (Dodds & Bowles, 2001; Kettles *et al*, 2004; Scottish Executive, 2002). Thus, the mental health nurse experiences a loss of control over his/her working practices, prescribed as they are by the psychiatrist from within the medical framework (Hall, 2004). Buchanan-Barker and Barker (2005) argue that by continuing to place the activity of observation at the centre of nursing practice, psychiatrists and the bureaucratic apparatus of the psychiatric system continue to exert control through the actions of mental health nurses.

Buchanan-Barker and Barker's (2005) conceptualisation of the practice of observation as a means of the psychiatric system exerting power over patients, resonates with Foucault's (1977) concept of panopticism. Panopticism involves surveillance and reporting within a hierarchical structure. It is a mechanism that allows the single individual (at the apex of the hierarchy) to exert power over those lower down the

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<sup>7</sup> Formal observations are a means of managing risk whereby, following assessment of the level of risk posed by a patient, the medical staff place them on one of three levels of observation: general observation is when the nurse is expected to know where the patient is; close observation where the nurse must be able to see the patient at all times; and special observation where a nurse remains within an arm's length of the patient at all times.

hierarchical pyramid through their knowledge that they are being observed, and the knowledge gained from that observation. It rests upon two principles defined by Bentham; surveillance should be visible, and unverifiable (Foucault, 1977). By this, Bentham means that those under surveillance should be aware that they are being observed. However, this surveillance activity should remain hidden, so that the inmate never knows when he is being watched. Panopticism is a disciplinary mechanism, it aims to develop a disciplined society as the individual under surveillance internalises the power relations within which he or she is entangled, modifying his or her action in line with the constraints of these:

*“He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon him self.”*

Foucault, 1977: 197

The use of observation and reporting on the ward therefore become the means through which discipline is achieved, and patients conform to the constraints of their position within the system. However, being subjected to the continual gaze of the powerful, leads to acts of resistance as subjects attempt to duck under this gaze (Foucault/Faubion, 2000). The experience of being subjected to the power of the mental health system was observed by Goffman (1961) to result in patients displaying what he termed *secondary adjustments*. These secondary adjustments were the means by which patients resisted the power of the system through their presentation, undertaking illicit activities, using irony and jokes. Goffman (1961) perceived these actions as the means by which the patients resisted being totally defined by the system, and were therefore a means through which patients expressed their individual identity.

2.3.4biii      *Observation as therapeutic opportunity:*      Observation is acknowledged as offering opportunities for therapeutic interaction between nurse and patient (Bray, 1999; Scottish Executive, 2002). However, in her ethnographic study of mental health nursing on three acute wards, Bray (1999) found that the nurses' actions, such as reading or sitting outside the patient's room distanced them from the patients. In his study of nurses' and patients' experiences of constant observation, Fletcher (1999) found that the nurses also displayed such behaviour. However, they perceived it as therapeutic, whereas the patients perceived such actions as controlling.

In order to facilitate engagement, it may be necessary to shift the focus of nursing away from traditional observation procedures. Dodds and Bowles' (2001) study examined the impact of refocusing the nurses' activities from observation to therapeutic engagement with patients. In order to gain time to spend with patients, the nurses were handed the power to alter observation levels, reducing the amount of time they spent carrying out formal observations because they did not have to wait for a doctor to attend the ward. This created the opportunity to spend time with patients on an individual basis. Spending time with the patients decreased the amount of risky behaviour exhibited by them as they valued the "*gift of time*" (Dodds & Bowles, 2001: 187) given to them by the nurses.

2.3.4biv      *Therapeutically oriented interactions with patients:*      The pattern of nurse-patient interactions is the focus of several studies. In their study of nurse-patient interaction on 10 wards in Northern Ireland, Whittington and McLaughlin (2000) found that less than 50% of nurses' time was spent in contact with patients<sup>8</sup>. Mental health Act commissioners found a similar lack of nurse-patient interaction during a series of unannounced visits in England. On arrival at just over a quarter of the wards in their sample they found that none of the nurses were interacting with patients (Ford et al, 1998).

Whittington and McLaughlin (2000), like Altschul (1972) nearly thirty years earlier, found that much of the patient contact time was focused on routine tasks: giving out medication (9.39%) and serving meals (5.8%)<sup>9</sup>. Social conversation accounted for 4.98% of patient contact time, and individual therapy of duration 5 to 45 minutes accounted for 6.11%. Whittington and McLaughlin (2000) believed that these times, when nurses came into contact with the patients by virtue of the ward routine, offered opportunities for nurses to engage therapeutically with patients. However, these opportunities were not taken.

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<sup>8</sup> See also Ryrie et al, 1998; and Bee et al, 2006

<sup>9</sup> Bee et al (2006) also identified the task-oriented nature of the activities classed by the nurses in their study as patient contact time.

Several other studies have reported a lack of therapeutic engagement between nurses and patients (Cleary & Edwards, 1999; Bray, 1999; SCMH, 1998; Baker, 2002; Rose, 2001; Walton, 2000; Ford *et al.*, 1998; Higgins *et al.*, 1999; Bee *et al.*, 2006). Patients interviewed in Higgins *et al.*'s (1999) study stated that they felt they did not get enough time with their key nurse and were often left to occupy themselves on the ward. In contrast, the nurses in Cleary's (2003) ethnographic study of an acute ward in Australia centred their practice on the importance of the nurse-patient relationship, prioritising their time so that they could meet with patients on a one-to-one basis.

The nursing focus on task-oriented contact with patients keeps nurse-patient relationships on a superficial level (Altschul, 1972). Consequently, Altschul (1972) perceived nurse-patient interactions to fall short of categorisation as relationships because they lacked emotional content. However, the patients in her study sometimes referred to a special relationship that they had developed with a particular member of staff. These patients' perceptions of such relationships as special seemed to be linked to the expression of empathy from the nurses.

The demands of others, and the pivotal role of the nurse in ward organisation means that even when patients do get to speak with the nurses, the interaction can be interrupted as the nurse is called away to attend to other issues on the ward (Cleary & Edwards, 1999; Clarke & Flannagan, 2003). However, Clarke and Flannagan (2003) found that even when the ward was quiet the nurses did not use this time to sit and talk with the patients. They noted that staff retreated to the office during quiet times on the ward, perhaps seeming to do paperwork but also chatting amongst themselves. They propose that the nurses use these quiet periods as a necessary down time, because in such a high-pressure environment as the acute ward it was impossible to be therapeutically accessible for an entire shift.

Dealing with disturbed behaviour, as indicated by the nurses in Hall's (2004) study also dominated nurse-patient interactions in Bee *et al.*, (2006) with more than half of patient contact time classified as "*containment*" (221). Breeze and Repper (1998) explored nursing staff's concept of the 'difficult' patient. 'Difficult' patients were those who exhibited disruptive behaviour, and challenged the competence of the nurses. The nurses in their study felt such patients took up a lot of their time,

resulting in feelings of resentment because this prevented them spending time with other patients who they perceived needed them more. Clarke & Flannagan (2003) also observed that patients who exhibited disturbed/disturbing behaviour were able to commandeer much of the nurses' attention, and those who were unable to express their needs to the nurses were often left unseen.

### *2.3.5 Patients' experiences of being nursed on the acute ward*

Research findings pertaining to patients' experiences of nursing activities can be subdivided under the headings of:

- ❖ Availability of the nurses
- ❖ Relationships

*2.3.5a Availability of the nurses:* The findings of the *Acute Problems* study indicate that 20% of patients stated that they disliked the attitude and availability of the nurses on the acute wards, making it the second most common dislike. Altschul (1972) found that the patients in her study liked the increased availability of the nurses in the locked section of the ward, sometimes requesting to return to the locked section despite the restrictions on freedom.

In *Acute Problems* (SCMH, 1998), as in other studies, patients complained that the nurses spent a lot of time in the office doing paperwork, making them inaccessible (Higgins *et al.*, 1999; Andes & Shattell, 2006; Rose, 2001). Such inaccessibility is derived from the office being a nursing space into which patients do not have free access. Patients therefore have to approach the office if they want to talk with a nurse, knock, and wait to be attended to. This places the nurses in a position to decide whether, and when, to engage with patients (Andes & Shattell, 2006).

*2.3.5b Relationships:* Availability of the nurses was perceived by patients in Moyle's (2003) study as necessary for them to feel nurtured. Other factors that made them feel nurtured were the nurses taking time to listen and help them talk about their problems, nurses taking time to calm them down, and being present. Patients reported these nurturing activities around the time of their admission to hospital, however, they reported that these nurturing activities ceased soon after. As their admission progressed, Moyle's (2003) participants began to feel that they were not nurtured as

the nurses became unavailable to talk, and the relationship was experienced as one in which the nurses held the power and the patients' views were attributed little value. The experience that nursing support was reduced may be linked to Cleary et al's (1999) finding that the nurses in their study perceived those who were more acutely ill, or who were new to the ward as most in need of their support. Thus, as their admission to the ward progressed and they became less new, and their illness became less acute, the nurses offered less support.

The attributes that made patients in Moyle's (2003) study feel nurtured resonate with the identification of good nursing practice by the participants in Rogers et al's (1993) study. Bad nursing practice was described in a similar way to not being nurtured, but included the nurses prioritising ward over patient needs, the practice of disrespectful or authoritarian ways of interacting, and the use of physical assault.

Coatsworth-Puspoky et al (2006) examined the process of the nurse-patient relationship from the perspective of the patient using an ethnography-based design. The findings enabled them to identify factors associated with the development of helpful and detrimental relationships.

Helpful relationships were associated with the initial friendliness of the nurse as someone who smiled and made patients feel secure. Trust was then developed as the nurse spent time with the patient, displaying empathy and treating them as a human being. Participants ended the relationship when they felt well enough to move on.

However, the patients' perceptions that their needs were not being recognised by the nurses, and that they were therefore not being offered the support they required, was identified as leading to the development of what Coatsworth-Puspoky et al (2006) defined as detrimental relationships. Frustration and anxiety resulted in the erection of barriers between patient and nurse. A cycle developed whereby the barriers led to patient and nurse avoiding each other, further reducing the availability of the nurse.

Putting up barriers that pushed the nurses away when dissatisfied with their care is a behaviour also noted by Sun et al (2006) in their study of suicidal patients in Taiwan. The 'difficult' patients in Breeze and Repper's (1998) study also displayed behaviour

that pushed the nurses away in their struggle to regain control over their care. These patients experienced a loss of control over how they were cared for in the ward. In response to this, the patients described how they struggled to regain control through non-compliance, violence, self-harm or by refusing to answer questions or continuing with banned behaviour.

## **2.4 Summary**

In this chapter I have introduced the main body of literature pertaining to this study. I have conceptualised mental health policy as the means through which the power of psychiatry is made visible. Recent policy upholds the political rhetoric of social inclusion and de-stigmatisation of mental illness. However, Goffman (1963) views stigma as a necessary group mechanism that allows a majority to define themselves as normal in relation to those defined as abnormal.

Within mental health, the diagnosis of some people as suffering from mental health problems categorises them as abnormal, and therefore outside the majority group of those who define themselves as normal. Thus, psychiatry, through the process of diagnosis, creates the conditions for stigmatisation. However, at the same time, the policies that shape mental health services attempt to de-rail this process.

Psychiatrists are granted the power to detain people in hospital through the Act. The implementation of these powers is based upon a judgement regarding diagnosis and treatment, and is often provoked by the need to manage risk. Thus, the Act becomes a tool of risk management. However, the Act is based upon principles of reciprocity, benefit and participation, which have been incorporated to uphold the human rights of those to whom it is applied. It is unclear who makes the judgement about whether these principles have been upheld, and whether, if a service provider is unable to uphold these principles whether they are still able to detain the patient in hospital.

The tensions identified within the Scottish mental health policy literature would therefore seem to derive from the conflict between the role of psychiatry as a powerful force in population management via categorisation of difference and the



ability to detain patients, and the politically acclaimed desires to create a society that is socially inclusive, and mental health services that provide support for people suffering from mental health problems. The role of the acute ward exemplifies this conflict as it attempts to balance the need to provide support with the need for risk management.

The picture of acute care that is developed through the literature review is one where patients report boredom and a lack of therapeutic input within the ward. Patients feel safe from the outside world, but feel threatened by the patients they are in with. The research highlights the dissonance between the nurse and patient perspectives pertaining to life on the ward.

The literature focuses on the nurse-patient relationship as the central facet of mental health nursing, yet research indicates that in practice this is not the case. Nurses become unavailable because of the competing demands made by the ward. The lack of nurse availability is thought to contribute to the development of poor relationships with patients. Studies indicate that nurses spend a large proportion of their time carrying out observations, yet findings of other studies indicate that these observations are experienced as non-therapeutic by patients.

This review highlights the gaps in current knowledge about acute care. In particular the lack of Scottish studies leaves practitioners in Scotland with no evidence base generated from within the policy context of Scottish mental health services. None of the studies reviewed used narrative as a method of exploring experience, thus, the novelty of the method used in this study has the potential to open up new areas of knowledge to the reader. The broad focus of the study on *experience of being a patient*, rather than on the experience of a particular aspect of acute care, opens up opportunities to achieve a new knowledge about acute care. Finally, there were very few studies that focussed solely on the experience of the patient. This study therefore adds to a small base, to increase knowledge of the patient's experience of acute care.

## 3 Representing Experience

### 3.1 Introduction

*“I cannot experience your experience. You cannot experience my experience. We are both invisible men. All men are invisible to one another. Experience used to be called The Soul. Experience as invisibility from man to man is at the same time more evident than anything.”*

Laing, 1967: 16

I began this research motivated by the desire to understand what it is like to be a patient on an acute psychiatric inpatient ward. I wanted to hear the voices of those who are often not heard. Through this thesis I want to allow these voices to speak to others, capturing their imaginations, moving them in some way. These desires have guided my choices and actions throughout the research process, raising issues about language, representation, narrative and discourse.

Representation is the motif that binds the threads of this discussion as it permeates all aspects of the research. Reality is conceived as experience (Laing, 1967), which is represented through the narratives we form to express our experience. This thesis, as a narrative of the research, is also a representation in which I represent not only my interpretation of the research process, but also my interpretation of the participants’ narratives which are themselves representations of their experience. Riessman (1993) identifies five levels at which experience is represented in the research process (see figure 3.1 below). As human beings, we represent the empirical world to ourselves as we think. We interpret these thoughts and express these to others, a further process of representation. As researchers transcribe and analyse interviews they have to make further interpretive choices. Thus, what is written as research reports are representations, filtered through the researcher’s interpretive process. Finally, the reader interprets the research report.

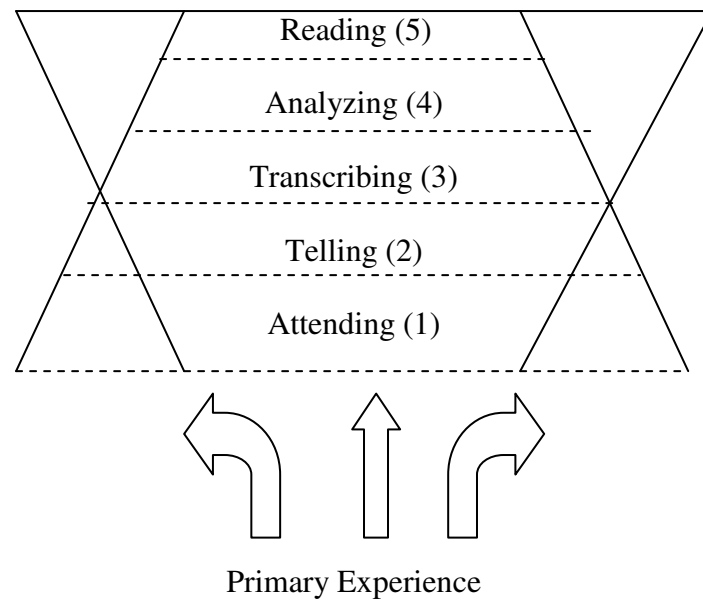


Figure 3.1: Levels of representation in the research process  
 Reproduced from Riessman, 1993: 10

Thus, what I am dealing with in this research are representations of experience in the form of narratives as data. Narratives are considered representations because they are linguistically crafted, and the meaning of language is not transparent, it is ambiguous, and contextually dependent. Narrative meaning therefore requires interpretation. Narratives are told in relation to an audience (either present or imagined, or both), influencing what is told and the form that telling takes. These narratives are told in the context of discourse, a source of concepts and language resources, through which the narrator interprets and expresses experience.

Discourse is the carrier of cultural norms, attitudes and beliefs (Gee, 2005). As individuals narrate their experience they draw on discourse, adding their narrative to that discourse, and thus perpetuating the cultural norms, attitudes and beliefs within the discourse. It is through discourse that narratives of one person connect to a community of narratives already told; it is this body of narratives that constitute the discourse.

As researcher, writing this thesis, my narrative is influenced by the discourses on which I draw: the disciplinary discourses of Nursing and Academia, gender discourses, discourses on mental health and recovery. How I hear the participants'

stories, how I represent these in my work, what I choose to focus on, are all influenced by my position within these discourses. In particular, my desire to have my work recognised within the discourse of narrative research, influences how I write. This creates tension with a nursing discourse where evidence-based practice has become the ideal, and the randomised controlled trial has been granted the status of gold standard of evidence. As I write, I become aware of this tension, noting the difficulties I experience in finding a voice that allows me to negotiate my way between these two positions.

The issue of finding a voice is that of allowing my perspective to become visible through the text. All texts have authors, and this text is written in a manner that does not deny this. Issues of voice are explored further in the first section relating to representation of others' lives. Issues of authorship and authority are discussed in relation to my desire to allow participants' voices to be heard within the text. This has led to me exploring creative ways of presenting data as a means of facilitating the development of aesthetic knowledge.

The second part of this chapter discusses the implications of conceptualising narrative as experience, that is, that our narratives become our experience (Frank, 1995). If self-identity is constructed through narrative, then our awareness of this as narrators has implications for what we narrate. This becomes even more explicit as I explore the links between discourse and narrative in the third section.

In the penultimate section I examine Gee's (2005) concepts of discourse models and situated meanings as I consider the interpretive process that occurs so that we can make sense of the narratives we hear. Finally, I consider some of the issues relating to the use of narrative as a way of knowledge creation.

### **3.2 Writing participants' lives**

This thesis is a representation; it is my narrative of the research. It is however, a cleaned up version, it does not show the to-ing and fro-ing of the research process, the cul-de-sacs and blind alleys that I entered as I felt my way through an evolving research process guided by my theoretical perspectives and research aims. It is my

account of events, shaped by my interests, values and beliefs, as well as those of my supervisors. Like any narrative, it is influenced by my audience; the examiners in the first instance, fellow academics, nurses and health professionals. This thesis therefore represents a partial, situated knowledge, a view from somewhere (Haraway, 1991).

Throughout the narrative of this thesis my voice is present. Voice, for Charmaz and Mitchell (1997) is not a technical literary device. It weaves its way through the text through thick description of the “*fieldwork phenomena*” (Charmaz & Mitchell, 1997: 195) as the researcher allows readers to hear her position within the research. It is an acknowledgement that no text is without an author (Lather, 1991), and rather than hide that author, allowing them to be present within the text. It is for this reason that I write in the first person, in an attempt to allow you, the reader, to begin to see from where I see.

This thesis is also a representation of the participants’ experiences as expressed through their narratives. Here I refer to the words of Rothman (1996: 51) as she describes her sense of what representation meant in relation to her aim of getting people to understand the experience of her participants:

*“‘Representing’ has two meanings, and in my work I move between them constantly. On the one hand, I represent these women as in a portrait: mine is a representational art. I need to find a way of making the highly edited, selected words of a very few people represent, draw a picture of, the situation of many. On the other hand, my representation is also a political representation: through my voice I represent theirs. I am their representative to the world that reads my words, hears me speak.”*

Like Rothman (1996) I perceive my responsibility as finding a way to represent the experiences of participants so that they resonate with others. Within this thesis are embedded the narratives of the participants, pieces of people’s lives, bound up with the hopes that motivated them to take part in the research, entrusted to me. The participants are patients in the mental health care system. To them I am an outsider, a nurse/researcher, someone who by virtue of our relative positions within the discourses on mental health might be perceived as occupying a more powerful position. How can I represent the lives of participants without silencing them through my authority? I experience a profound sense of responsibility as I write, aware that

whilst I might be able to give up my authority over those about whom I write, I cannot give up the responsibilities of authorship (Richardson, 1990).

The process of writing is embedded in power structures, with the ability to reproduce or disturb dominant power relations (Bertram, 1998; Lather, 1991; Richardson, 1990). Bertram (1998) identifies that many feminist authors, having identified this, adopt writing practices that attempt to circumvent what she terms the authority effect. These writers place themselves within their texts by making their positions explicit, thus shedding the illusion of the authoritative view from nowhere, instead situating their knowledge. However, allowing one's personal position to speak within the text, and making oneself the central feature of the text have vastly different consequences. Whilst the former position might be thought of as decentring the researcher's authority, the latter position, occupied by auto-ethnography/biography runs the risk of shifting the focus entirely onto the researcher. Here individual experiences are lost as the researcher's experience is assumed to talk for all women, men, lesbians and others (Bertram, 1998; Lather, 1991).

Fine et al (2003) approach the issue of authority by examining the space where researcher and participant interact: the self-other hyphen. In doing what Fine (1994) terms *working the hyphen*, researchers examine their position in relation to the other. This hyphen is the space where both knower and known are getting to know each other and, if the dynamics of this relationship are explored, the objectification of participants can be avoided (Deutsch, 2004). Knowledge is therefore viewed as jointly produced by researcher and participant in relation. Within this research the narrative data is conceived as co-produced through the relation between participants and myself.

Whilst there are ways in which researchers can attempt to usurp some of their authority within research writing, the written text remains the responsibility of the writer (Freshwater, 2007a; Richardson, 1990). As Richardson (1990: 12) states:

*“When we write social science, we are using our authority and privileges to tell about the people we study. No matter how we stage the text, we – as authors – are doing the staging. As we speak about the people we study, we also speak for them. As we inscribe their lives, we bestow meaning and promulgate values.”*

Unable to escape the responsibility of authorship, those who wish to reduce the authority of their own voice and allow others to be heard through their research have experimented with different methods of representation. Poetry, plays, and short stories have all been used in an attempt to decentre the voice of the researcher. These different methods of representation disrupt the usual writing practices of the Academy (Universities and other academic institutions) (Bertram, 1998; Lather, 1991). They create distance between the data and the world, celebrating its interpreted nature, openly acknowledging the data as representation (Lather, 1991; Oikarinen-Jabai, 2003). Lather (1991) recognises that whilst nothing short of full collaboration will prevent some level of objectification, the use of such experimental forms has the potential to redress the “*introspection/objectification balance*” (150).

The use of such creative forms of writing to get participants’ voices to speak through the text, aims to involve the reader, draw them in, to evoke particular feelings. Shklovsky (1965) contends that the role of artistic forms of representation is to make the familiar unfamiliar, thus requiring that the reader attend more carefully to it. He argues that because we are used to reading/hearing in the form of prose, then we stop perceiving the detail:

*“The object perceived thus in the manner of prose perception, fades and does not leave even a first impression; ultimately even the essence of what it was is forgotten”*

(Shklovsky, 1965: 11).

Kendall and Murray (2005) support this argument with their findings that when people read the same piece of data presented in prose and poetic form, they skimmed the prose to pick out the salient points, whereas they read the poetry much more slowly, repeating the rhythm of the words in their heads.

Clarke et al (2005) used poetic form to represent the stories of people with mental illness. Having written the report in prose format they did not feel satisfied that it allowed the voices of participants to be heard. They developed poetic representation of the stories which they perceived as allowing the particulars of the participants’ experiences to speak. In this way they suggest that the participants were less objectified, and the audience was able to connect with the elements of their stories –

suffering, hope, strength – on a human-to-human basis (Clarke *et al*, 2005; Hunter, 2002).

It is aesthetic, rather than scientific, knowledge to which poetic representation facilitates access (Kendall & Murray, 2005; Holmes & Gregory, 1998; Kidd & Tusaie, 2004). Poems are openly interpretive, and require interpretation. They offer insights into others' experiences through the imagery used, and they allow readers to recognise their own experience within them (Holmes & Gregory, 1998). In this way poems allow readers to make emotional connections with participants' stories (Clarke *et al*, 2005; Kendall & Murray, 2005; Hitchings, 1969; Richardson, 1992; Hill, 2005; Holmes & Gregory, 1998), and the opportunity for empathy with the participants (Kidd & Tusaie, 2004). Empathy and emotional connection are central features of aesthetic knowledge, a form of knowledge essential for nursing with its focus on nurse-patient relationships (Kidd & Tusaie, 2004; Hunter, 2002; Freshwater, 2007b).

Charmaz and Mitchell (1997: 195) warn, however, that such creative forms of writing are not necessarily evocative:

*“...[U]nfamiliar forms [of writing] in unaccustomed hands may produce products that are more self-conscious than evocative.”*

Like Richardson (1992), Lather (1991), Lieblich (2006) and so many others, I have chosen to disrupt the norms of academic report writing, in an attempt to decentre my own voice. Like Rothman (1996), I hope that through my voice you can hear the voices of those who participated.

### **3.3 Representing experience as narrative**

#### *3.3.1 Narrative expression of experience*

*“The stories we tell about our lives are not necessarily those lives as they were lived, but these stories become our experience of those lives.”*

Frank, 1995: 22

*“One of the primary ways – probably the primary way – human beings make sense of their experience is by casting it in a narrative form...”*

Gee, 1985: 11



*“Personal narratives are very explicit ways of representing reality, because tellers choose what to include in them. Individuals create who they are, and the definitions of their situation that they want listeners to adopt in their biographical accounts. Narratives are reductions and distillations too, because they make the complicated upheaval of our world, at least in part, orderly, predictable, bounded.”*

Riessman, 1991: 44

As human beings move through the world, we receive primary information through the senses. We note some of the information from this constant flow as salient and label it using the classificatory terms of the language that is available to us as members of particular social groups. Thus, we represent the objects in our world to ourselves in linguistic form as the first level of Riessman's (1993) model (see figure 3.1). These objects are then interpreted in line with our attitudes, interests, beliefs, values and previous experience and knowledge (what I will term our world view) and become our experience (Polkinghorne, 1988). These experiences are formed into narratives that we tell ourselves, and others, as we make sense of the world. Thus language is used to both label objects in our world, and to express our interpretations of this world. As we narrate our experiences we are simultaneously creating our reality and expressing it through our linguistic choices (Gee, 2005; Jakobson, 2006; Bruner, 1991).

How we use language, the grammatical choices we make when forming narratives, allows us to create a version of reality, our experience, from a particular perspective (Gee, 2005, 1990). Frank's (1995) quote refers to the representative nature of stories, they do not mirror events in the empirical world - *“those lives as they were lived”* - but offer a version of events (Bruner, 1991). When we narrate our experiences we bring our internal life into the public domain; the world view that informs our interpretations of events becomes visible. Through their narratives we can see how people make sense of the events in their lives, how they attribute causality, and the connections that they make between disparate events (Werner et al, 2004; Gale et al, 2003; Rosenwald & Ochberg, 1992). Narratives, therefore, say as much about the narrator, as they do about the events they describe (McLeod, 1997).

Our stories, as our experience (Frank, 1995), are incorporated into our personal history constituting our identity. We become known to ourselves, and others, through our narratives, we become the stories we tell (Riessman, 1993). Identity is, thus, constituted through narrative, allowing individual's to make claims about their lives, and who they are (Rosenwald & Ochberg, 1992; Riessman, 1991). It is because we are constantly in the process of creating the self, of becoming through narrative, that narratives have such personal meaning for us (McLeod, 1997).

Like the identities they constitute, narratives are not fixed; what is told and how it is told is dependent on the context in which the telling occurs (Gale *et al*, 2004; Riessman, 1993). All narrative is formed in relation with another person, and is influenced by this relation. The audience may be present or imagined, known or unknown. Nonetheless, the narrator makes assumptions about their status, values and beliefs. Harding (1998) argues that all human beings occupy positions at the juncture of hierarchical social locations, such as gender, class and race. These positions are linked to the distribution of social goods, as particular positions are more acceptable or desirable than others.

Awareness of our location, and our assumptions about this in relation to the location of others, is experienced as the power dynamic within the relationship. Our assessment of where we sit within these power relations has implications for what we are willing to reveal about ourselves in our narratives. Such actions are guided by the need to maintain a valid social identity for ourselves. The assumptions that we make about the audience therefore close down, or open up, narrative opportunities.

Preservation of a valid social identity is the basis of what Riessman (1990b) refers to as the *teller's problem*. Our awareness of the individual nature of our experience gives rise to the need to persuade the audience of the validity of our version of events. Thus, as tellers we are challenged to structure our narratives in a way that achieves this. In her study of people's accounts of divorce, Riessman (1991) found that her participants devoted swathes of narrative to portraying the break up of their marriages as justifiable/inevitable. Participants adopted different styles of narration (genres) for different persuasive purposes. For instance, the continual recurrence of particular events formed the habitual narrative of one participant, in a manner that indicated the

inevitability of the break-up. Thus, narrators make conscious choices about how to structure their narratives - what to include or omit, how to position themselves, what tense to use, to use verbatim statements or talk in general terms, the imagery and metaphors they use, and so on - to fulfil their persuasive function.

The narrator, however, is not the sole producer of the narrative. As well as the narrator's assumptions about the audience shaping the narrative, the audience (if present) take an active role. Narratives require interpretation because of the ambiguous nature of language. As they interpret what they hear, listeners interact with tellers in order to check out their interpretations, get some clarity on what the point is, or offer alternative interpretations. These interactions constitute a process of negotiation, where the meaning of a narrative is negotiated in the space between teller and listener (McLeod, 1997; Riessman, 1991). The listener's interpretations, and therefore his or her interjections, are generated from within their own experience. The narrative is therefore the product of a negotiation in which the world views of both parties, through the interaction between teller and listener, are influential. Thus, narratives are referred to as co-constructions where meaning is locally negotiated and situated, that is, the product of a particular social and historical context.

### 3.3.2 *Discourse as context for narrative*

*"A Discourse is a socially accepted association among ways of using language, of thinking, feeling, believing, valuing, and of acting that can be used to identify oneself as a member of a socially meaningful group or 'social network', or to signal (that one is playing) a socially meaningful 'role'."*

Gee, 1990: 143

Gee (1990, 2005) contends that the main work that discourse does is to make a person recognisable as a particular kind of who doing a particular kind of what. Discourses provide us with the tools we need to occupy, and recognise others as occupying, various subject identities in our daily lives (Gee, 1990, 2005; Gubrium & Holstein, 1995). They constitute a set of values, ways of thinking, beliefs, language, props, actions and other things that are associated with a particular subject identity.

Discourses weave their way through the fabric of society, being constantly enacted by individuals as they live their lives. Through this enactment the norms and values of social groups are continually perpetuated (as they are the basis upon which identities become recognisable). Membership of particular discourses provides individuals with particular language resources to enable them to narrate their experiences (Gee, 2005). These language resources are grounded in the beliefs, attitudes, values and so on that constitute the discourse. Narratives are therefore inscribed with the values and norms of the discourses upon which the narrator draws (Riessman, 1990a).

Norms and values define what is desirable or acceptable and are therefore associated with the distribution of social goods. Discourses are therefore intrinsically linked to issues of power, they are always ideological (Gee, 1990). Gee (1990: 23) defines ideology as a “*social theory ... which involves generalizations ... about the way(s) in which ‘goods’ are distributed in society.*” Such theories are developed either through our personal experience and research, other’s reports, or our assumptions that someone with expert status will know the basis for supporting that theory (Gee, 1990). These theories shape our beliefs, forming the basis of our actions. By goods, Gee (1990) is referring to anything that human beings consider necessary or desirable for living. Gee (1990: 23) states the importance of ideologies as follows:

*“Ideologies are important because, since theories ground beliefs, and beliefs lead to actions, and actions create social worlds (‘reality’), ideologies simultaneously explain, often exonerate, and always partially create (in interaction with history and the material bases of society) the distribution of goods.”*

If discourses are ideological, meaning that they are concerned with the distribution of goods, then they are intrinsically linked to the power structures of societies (Gee, 1990; Jaworski & Coupland, 2006).

It is within the context of discourse that individuals narrate their experiences, and thus within the context of society’s power structures. Narrativisation is therefore a political activity, concerned with the social distribution of goods (Plummer, 1995). Within a discourse some viewpoints dominate, marginalizing others. The marginalisation of particular viewpoints closes down the possibility of narrating particular experiences. However, discourses change as the people who enact them,

whilst remaining recognisable as members of a particular discourse alter the criteria for being recognised as part of the discourse, for example, by introducing aspects of other discourses (Gee, 1990). Thus, discourses evolve, and with this evolution come the opportunities to tell new stories - those that were previously silenced (Riessman, 1990a; Plummer, 1995).

Riessman (1990a) cites an example of how this occurred during her research with people who experienced divorce. One of her participants had left her marriage because of marital rape. When she originally left the marriage the legal system within that State (in USA) did not recognise marital rape, closing down the opportunity to narrate her experience in these terms. However, several years later the evolving legal discourse had opened up the opportunity to tell her story in new terms, as a story of marital rape.

Similarly, Plummer (1995) discusses the way in which the changing discourses on gay and lesbian sexuality have presented new opportunities for people to tell their stories. In the same way, one might consider how the changing discourses pertaining to mental health have altered what people with mental illness, whose voices were marginalised, are able to tell. For instance the development of discourses of recovery offer new resources for narrating experience, where before only illness discourses were available.

Within the study, participants' narratives are shaped by the many discourses that provide them with the language resources to interpret and narrate their experiences. The positions that participants occupy within the power structures of society will both facilitate and close opportunities to narrate particular kinds of stories.

### 3.3.3 *Situated meanings and discourse models*

*“Neutral dictionary meanings of the words of a language ensure their common features and guarantee that all speakers of a given language will understand one another, but the use of words in live speech communication is always individual and contextual in nature”*

Bakhtin, 2006: 105

Bakhtin's (2006) statement indicates the complexity of language. Whilst words have general meanings that are adopted throughout a social group, their meaning is also specific to the context in which they are uttered. That is, meaning is situated, dependent on context (Gee, 1990, 2005; Werth, 1999; Shotter, 1993). In this section I will discuss Gee's (2005) concept of discourse models as the basis of interpreting the meaning of texts. Gee (2005) argues that as we participate in social interaction we are constantly assembling situated meanings. These situated meanings are developed from a variety of features in the context that we link together to form the meaning of a particular word in that particular context. Thus the same word in different contexts can have different situated meanings.

Gee (2005: 65) gives the example of the different situated meanings for the word "coffee". Uttered in the following sentences, "the coffee spilled, get a mop" and "the coffee spilled, get a broom" we can construct different situated meanings for coffee based on the clues given in the context. In the first statement, the word "mop" triggers the application of our knowledge about mops, and we are likely to develop a situated meaning for coffee such as "a dark liquid, probably hot". In the second statement, the word "broom" evokes our knowledge and experience of such matters, and we develop a situated meaning of "dry brown powder or grains" or "dark reddish beans" for coffee. Thus, we develop the situated meaning of the word coffee from our knowledge evoked by different aspects of the context in which it is uttered. The situated meaning is therefore assembled based on the context of the word.

Gee (2005) argues that the process for assembling situated meaning is guided by a discourse model. Discourse models are theories that we develop to explain the world and our experiences in it. They are based upon the values, norms and other aspects of discourses. Such theories are simplified, formed from individuals' experiences and what they perceive are the essential elements of that discourse. They are then applied to situations, providing a rationale for the assembly of a situated meaning from the various diverse facets of the context. Much of this process is unconscious as discourse models are applied to habitual contexts.

Discourse models are the means through which the value systems implicit in discourses are applied to local situations. In this way, they represent the practical

application of the value systems present in discourses to the everyday world that we live in. Participants in the study have therefore applied their discourse models to the situation of being a patient in the acute ward in order to make sense of that experience. In the same vein, I interpret the narratives of participants' experiences using the situated meanings offered me by the discourse models upon which I draw.

However, interpretation of meaning is not the sole responsibility of the listener/reader. Gee (1990) and Shotter (1993) both argue that the manner in which a speaker makes a point is instructive of the interpretation that the hearer should adopt. The emphases and word order of a piece of text indicate the information that the speaker wants the hearer to take as important (Gee, 1990; 1991; Shotter, 1993). Gee (1990: 84) proposes that speakers include some words in their utterances in order to exclude others, and it is the hearer's evaluation of these words against their normal context of use that allows him or her to guess at their intended meaning:

*“Words have no meaning in and of themselves and by themselves apart from other words. They have meanings only relative to **choices** (by speakers and writers) and **guesses** (by hearers and readers) about other words, and **assumptions** about contexts.”*

(Emphases in the original)

Shotter (1993) argues for a similar process whereby speakers make some things “rationally visible” (102), making it clear what it is they are talking about and from what perspective. In this way, they point listeners toward how to interpret the flow of activity. In making some things rationally visible, speakers then narrow the possibilities of looking at things in a different way. Thus, the options for interpreting the meaning of a text are defined by the speaker.

Interpretation of meaning is always therefore a joint effort on behalf of speaker and listener who draw on their knowledge of the world (Gee, 2005; Shotter, 1993; Werth, 1999). Speakers set the parameters for possible interpretations of the text through use of grammar and narrative structure that form the context of a word. Listeners tap into their socio-cultural knowledge, in the form of discourse models, in order to assemble situated meanings (Gee, 2005; Werth, 1999).

### 3.3.4 Narrative structure and meaning

In this section I discuss Gee's (1991) conceptualisation of how narrators convey meaning through the structure of their narratives. Gee (1991) considers the grammatical devices and organisation of a narrative to be the key to interpreting its meaning. He considers the possible interpretations of a narrative as delineated by the structure of the text: the idea units, lines, focuses and other structural components. Each of these structural components makes a particular contribution to the interpretation of the narrative. In his 1991 paper, Gee set out his theory of meaning as it relates to the narrative structures he identifies. In this theory he proposes that interpretation takes place on five hierarchical levels, each linked with particular narrative structures. Table 3.3 below summarises these levels:

Table 3.3: Five levels of structure in a narrative text with their contribution to interpretation and how they are formally signalled

Level	Formal Marking	Role in Interpretation
1. Line and stanza structure	Patterning	Ideas and perspectives on characters, events, states, information
2. Syntax and cohesion	Word order and grammatical words	Logic and connections
3. Main line/non-main line	Verbal system and aspect	Plot
4. Psychological subjects	Grammar	Point of view
5. Focussing system	Pitch and stress	Image/theme

Reproduced from Gee (1991): 27

The contribution that each aspect of a narrative's structure makes to meaning is illuminated in the above table. Analysis of narratives following these concepts



facilitates the development of interpretations that take into account the speaker's layered use of structure to build meaning. The material examined at each level sets up interpretive questions which are answered through the analytic activity at level five. It also, however, sets limits on which interpretive possibilities make sense, because the interpretations must make sense within the context of the narrative as well as within the available discourses.

Gee (1991) contends that the general rhythm of speech, prosody, is a conscious creation of the speaker in order to convey their perspective. Through the use of prosodic devices, the narrator organises his or her speech into discernable structures; lines and stanzas. Lines generally contain one idea unit, and have a base pitch which rises or falls (a pitch glide) to indicate the material that the speaker considers to be the new, or important information contained in the line (the focus material). Lines are organised into stanzas, grouped together so that they have an even rhythm and each stanza portrays a particular perspective like a single photographic image.

In order to group the lines of a narrative together to form stanzas, and ultimately a narrative, the speaker must employ *cohesive devices* (Gee, 2005: 191). These are used to link what is currently being stated to what has already been stated, often by acknowledging that some piece of information has already been given. For instance, 'them' refers to characters that have been introduced previously in the text. Cohesive devices may also indicate the narrator's perception of the relation between two pieces of information. For instance, 'because' indicates a causative relationship, whereas, 'however' indicates a contradictory, or negative, relation between the two lines. Focussing on the narrator's use of cohesive devices thus makes visible for the listener/reader the logic and connections that the speaker/writer perceives between the ideas expressed in lines of the narrative.

Moving beyond the order and connections between the words in the narrative, to focus on the choice of words that are used allows the listener/reader to identify the point, or plot, of the story. Gee (1991) identifies what he terms *mainline* and *non-mainline* material. The mainline material outlines the plot of the narrative, and generally takes the form of simple past tense: this is what happened. The non-

mainline material is no less important as it contains the material that comprises the context of the plot.

The point of view from which the narrative is told is discernable by examination of the grammar used. This point of view varies over the course of a narrative, for instance, 'I' might become 'we' conveying a shift from the narrator perceiving themselves as singularly responsible for the events described, to the inclusion of others as co-conspirators in the plot. Identifying the narrator's point of view, and how this shifts within the narrative, leads to questions about why the narrator changes his or her point of view; what is the narrator trying to convey through his or her shifting position?

The final layer of narrative through which meaning is conveyed is the pitch and emphases evident in the narrator's speech. Variations in pitch are indicative of what Gee refers to as *focus material*. Gee conceives of the focus material as being central to the analysis of the data. This is material that the speaker is drawing the listener's attention to, and it offers additional perspective, although it does not change the literal meaning of the statement. Focus material evokes images and themes, and these set the parameters from within which the speaker wants the listener to interpret the narrative.

Thus, Gee's (1991) model, linking narrative structures and their interpretive roles, offers a comprehensive framework for use when analysing narrative. Its focus on structure as the start point for the analysis of narrative resonates with Riessman's (1993) approach to analysis: begin with the structure and expand out the way. As such, it provides a means of grounding the interpretation of the participants' narratives in their own sense-making structures rather than that of the researcher.

### 3.3.5 Narrative knowing

*“Investigators do not have direct access to another’s experience. We deal with ambiguous representations of it – talk, text, interaction, and interpretation.”*

Riessman, 1993: 8

*“...[T]he focus of a narrative oriented qualitative methodology is the way people tell their stories, rather than the accuracy or otherwise of the account...Neither the realities of lived experience, nor the integral role of interpretation are ignored. Rather, the focus is on the relationship between experience and interpretation revealed in the narrative.”*

Ezzy, 1998: 173

We cannot access unprocessed experience, we can only access experience through individuals’ expressions of it. These expressions, in narrative form, are the means by which individuals represent their experience of the world to themselves and to others. They are interpretations, infused with the individual’s values and beliefs, assumptions about the audience, and the values of society as perpetuated through the discourses in which individuals’ narratives are embedded. Narratives are therefore creations, not mirror images of the empirical world (Riessman, 1993). They are linguistically formed representations of individuals’ interpretations of events.

I chose to quote Riessman (1993) because she captures the essence of the problem for those wanting to research human life; that is, we only have individuals’ representations to work with. These narrative representations are constituted through language, yet language is ambiguous, not corresponding directly with the objects in our world. As discussed in section 3.3.3, language is infused with values, and meaning is contextually dependent. Narrative representations therefore simultaneously are interpretations and require interpretation. The narrative represents the narrator’s interpretation of events, and because language is not transparent, the narrative requires interpretation by the listener/reader.

These layers of interpretation render the meaning of narratives as contextually situated. This and the fluidity of narratives as they are shaped by the context of their telling, means that one can consider the results of researching another’s experience

through narrative as contextually dependent snapshots, representative only of the moment.

A further issue of using narrative to find out about the world is that of ‘truth’ (Riessman, 1993). The argument may be advanced that individuals might withhold information, or actively look to deceive others, and that this would diminish the value of the knowledge gained. The issue at stake is captured by the following quote from the Personal Narratives Group (1989: 261) (emphasis in the original):

*“When talking about their lives, people lie sometimes, forget a lot, exaggerate, become confused, and get things wrong. Yet they **are** revealing truths. These truths don’t reveal the past ‘as it actually was’, aspiring to a standard of objectivity. They give us the truths of our experiences.”*

Individuals’ psychological defence mechanisms can decrease access to their experiences, particularly if these are traumatic (Riessman, 1993). Memories may be blocked in order to preserve the integrity of the self. This blocking occurs in relation to the individual’s awareness of what is socially acceptable to tell, and thus, where some subjects are taboo, the individual is denied the language to name what happened (Riessman, 1993). Thus, people’s narratives are shaped by what they can remember.

Researching others’ experiences through narrative therefore has to take these issues of narrative creation into account. Narratives are not conceived as directly referring to events in the empirical world, they are treated as contextually located representations. Narrative research aims to get at the subjective interpretations of its participants (Rosenwald, 1992; Personal Narratives Group, 1989; Ezzy, 1998). Gubrium and Holstein (1995: 47) summarise the epistemological approach underpinned by this theoretical position as follows:

*“If we treat talk and interaction as the means through which lives are constructed, we direct our attention to what participants actively “do with words” to structure and give social form to experience. Interpretive practice – the activities through which persons understand, organise and represent experience – becomes our focus.”*

Thus, it is not the content of the narrative regarding the material world, but more the insight it offers into how the narrator interprets the world, that is the focus. By treating narrative as an expression of how an individual interprets events at a particular social and historical point, the question of its ability to truly represent what

happened in the empirical world is circumscribed. Treating narrative in this way, as an interpretive product, allows researchers to consider all individuals' narrative expressions of experience as valuable.

### **3.4 Summary**

In this chapter I have set out the theoretical assumptions that underpin this study. Representation is the main theme that binds the different elements of the chapter together. We can only know our own experience, and therefore rely on others' representation of their experience as data within the study. Narrative is considered as the form of representing experience, and this throws up issues pertaining to language and meaning.

This thesis is also a narrative account, a linguistic representation of this study. As such it represents a situated knowledge. As researcher I am inextricably bound into the processes of research and writing, and this is made explicit through my use of first person within the thesis. This thesis, as a narrative account, also represents the narrative accounts of those who took part in the study. Whilst unable to avoid the responsibilities of authorship, I discussed the need to decentre my voice and allow those of the participants to be heard. Alternative means of presenting participants' stories are one way of decentring my voice. Poetry in particular is thought to invite readers to engage, and evoke images and emotion that facilitates the development of aesthetic knowledge that is central to nursing.

I have treated narrative as both constituting experience and the means of expressing experience. It occurs within the context of discourse the language resources of which narrators draw upon. Thus narratives perpetuate the values and norms represented within a particular discourse. Whilst discourses offer the individual the resources for interpreting and narrating experience, their link with societal power structures results in them facilitating or inhibiting the telling of particular narratives.

Narratives are linguistic constructions that are influenced by the context in which they are told, and whose meaning is not transparent. Meaning is interpreted by drawing on knowledge pertaining to the normal use of words in particular contexts. The assembly

of these situated meanings occurs within the parameters of the discourse models that allow the values and norms of particular discourses to be applied to local contexts. In this way cultural values and norms are perpetuated through narratives.

The interpretation of meaning is not the sole responsibility of the listener, but is guided by the narrator through the structural properties of the narrative. Gee (1991) identifies five levels of narrative structure that each contribute to the interpretation of the narrative. Attention to how the narrator constructs his/her story can therefore provide clues to the meaning that they intend to convey.

## 4 Researching Experience: Research Design

### 4.1 Introduction

*“If, however, experience is evidence, how can one ever study the experience of the other? For the experience of the other is not evident to me, as it is not and never can be an experience of mine.”*

Laing, 1967: 16 (emphases in the original)

In Chapter Three I discussed theoretical concepts pertaining to the representation of experience. In the above quote Laing (1967) problematises the issue of studying the experience of an individual other than oneself. In this chapter I give a detailed account of the research design aimed at capturing and exploring the experience of others. The research design is based upon the theoretical concepts pertaining to narrative, experience, representation and meaning discussed in Chapter Three.

In Chapter Three I developed the epistemological position taken within the study: that it is only possible to know the experience of others through their accounts of that experience, and these accounts are representations, influenced by the context in which they are constructed. The language used by the individual to represent their experience is not transparent, and requires interpretation. This epistemological position is upheld by the adoption of a qualitative approach to the research.

A consideration of ethical issues was central to the research design; Shaw (2003: 9) describes this as a need for “*reciprocity between methodology and ethics*”. The highly personal nature of narrative, providing detail of people’s lives, renders participants in narrative studies especially vulnerable, particularly in terms of anonymity (Chase, 1996; Shaw, 2003). Josselson (1996: 70) claims that researchers should carry out narrative research “*in anguish*” as we balance the vulnerability of the participants with the need to retain the personal nature of the narrative for it to be of value to others. In this study, where the research relationship was pivotal to the method, ethical issues were a continuous concern (Shaw, 2003; Truman, 2003; Dench *et al*, 2004).

The centrality and perpetuity of ethical issues within the research has led me to intertwine my discussion of ethical issues with my discussion of the research design. In the first section of this chapter I introduce the main ethical principles upon which the research design is premised. These issues are discussed theoretically, without specific reference to this study, so that the reader can gain a sense of what they entail. Discussion of how these principles are applied to the research is included in each section pertaining to the research design.

## **4.2 Ethical principles**

### *4.2.1 Introduction*

The process of gaining access to an NHS site for the purposes of this study required that I apply for ethical approval of the study. The application procedure, situated within the context of the NHS, was medically oriented and focussed on issues of harm and risk. As such, the researcher's obligation to participants was perceived as the prevention of harm as a consequence of participation in the research. The nature of the study made it impossible to know at the beginning what might cause harm to participants, and indeed, what they might perceive as harmful. Thus, I had to remain constantly mindful of ethics throughout the research process. This places a continuous awareness of ethics within the domain of an honest and respectful research relationship (Hollway & Jefferson, 2000).

In this section I introduce and discuss the main ethical principles underpinning the research under the following headings:

- ❖ Voluntary participation
- ❖ Informed consent
- ❖ Anonymity and confidentiality

### *4.2.2 Voluntary participation*

In order to uphold the individual's human rights, participation in research should be voluntary (Dench *et al.*, 2004). Recruitment strategies should ensure that potential participants are not coerced to take part. Voluntary participation can only occur if the participant actively consents to taking part. However, for participation to remain voluntary, following initial consent the participant must give continuing consent, and



it follows, that should they wish to withdraw their consent, and therefore their participation, this should be possible at any point of the study.

The decision about whether or not to participate cannot be freely made without the potential participant being privy to information pertaining to the research and its possible impact on the individual's life. Thus, participation can only be voluntary if the individual is able to make the decision to consent on an informed basis.

#### 4.2.3 *Informed consent*

Voluntary participation in a study therefore requires the participant to give informed consent. Informed consent is a concept more generally associated with the transfer of legal responsibility for the consequences of a proposed action. By giving consent the individual takes responsibility for the consequences of the proposed action, and in turn, by informing the individual of the consequences of the proposed action, the other party disclaims any liability for harm experienced (O'Neill, 2003; Dench *et al*, 2004; Truman, 2003). This approach to informed consent may be appropriate in a situation when the consequences of the proposed action are known. However, the nature of qualitative research, through its reliance on social interaction, precludes the researcher from knowing, and therefore being able to inform participants of, the consequences of the research before it has taken place (Shaw, 2003; Dench *et al*, 2004; Hollway & Jefferson, 2000; Corbin & Morse, 2003). The concept of informed consent in qualitative studies must therefore be reconsidered to allow for this uncertainty.

O'Neill (2003: 6) defines informed consent as follows:

*“Patients, research subjects, and tissue donors give genuine consent only if they are neither coerced or deceived, and can judge that they are not coerced or deceived; yet they must not be overwhelmed with information. This balance can perhaps be achieved by giving them a limited amount of accurate and relevant information and providing user friendly ways for them to extend this amount ...as well as easy ways of rescinding consent ... Genuine consent is apparent where patients can control the amount of information they receive, and what they allow to be done”.*

The crux of informed consent for O'Neill is therefore the participant's perception that they have been neither deceived nor coerced during the research process. Thus

informed consent becomes a continuous process, a facet of the research relationship, not simply a procedure to be followed at the beginning of the research relationship. In this respect it becomes the responsibility of the researcher to protect the participant from harm through the development of a relationship based on “*the values of honesty, sympathy and respect*” (Hollway & Jefferson, 2000: 99).

#### *4.2.3a Capacity to give consent*

Alongside the need for enough information, the potential participant must have the capacity to make decisions pertaining to consent to participate. Such decision-making capacity is often not attributed to those suffering from mental illness (Davies, 2005), and was a source of concern within the Local NHS Research Ethics Committee (LREC). However, mental illness, in the opinion of several authors, should not prevent a person from being able to carry out these decision-making activities (Van Staden & Kruger, 2003; Cuenod & Gasser, 2003; Mental Welfare Commission, 2002b).

The *Adults with Incapacity (Scotland) Act 2000* (Scottish Executive, 2000) defines capacity to make decisions regarding participation in research as the ability to make, communicate, understand and remember decisions. Capacity to consent to participation in research might be considered differently to capacity to consent to treatment (Davies, 2005). ‘Non-compliance’ with treatment is often perceived by health professionals as a person’s lack of capacity to make decisions about treatment, and is a common reason for patients to be treated under a section of the Mental Health Act. However, such non-compliance may have more to do with the person’s attitude to illness and treatments, than their capacity to make decisions (Davies, 2005). Thus, persons treated under the Mental Health Act do not necessarily lack the capacity to make decisions regarding participation in research, and should not be excluded from participation (Mental Welfare Commission, 2002b).

#### *4.2.4 Anonymity and confidentiality*

Narrative research, through its reliance on detailed stories of people’s lives, leaves its participants open to being recognised. Anonymity refers to attempts to hide identity within the products of research (Grinyer, 2002), reducing the likelihood of recognition

by others. It is generally sought through the use of pseudonyms, and the deletion of other identifying details.

Within the products of narrative research, the use of narrative extracts to convey meaning to the audience must be balanced with the need to protect the participants. The exclusion of details of particular events will change the reader's ability to grasp the meaning of the participants' stories as represented in the text. Thus, a balance has to be reached between protecting the participants from the negative consequences that might arise from publication of certain details, and the loss of meaning within the research itself through deletion of contextual material. Judgements regarding what should be made public and what should remain in the private domain are based on the researcher's values and interpretations. As such they may conflict with participants' own judgements (Christians, 2003).

Confidentiality is the assurance "*against unwanted exposure. All personal data ought to be secured or concealed and made public only behind a shield of anonymity*" (Christians, 2003: 218). Thus, through the process of anonymity a participant's confidentiality is maintained. Issues of confidentiality and anonymity are central to the formation of trust within the research relationship, yet it is naïve to imagine that researchers can guarantee either (Christians, 2003; Ensign, 2003; Shaw, 2003; Truman, 2003). There may also be limits to the levels of confidentiality that the researcher is allowed to keep, particularly with respect to risk, or harm to others.

#### *4.2.5 Ethical approval*

Prior to the commencement of the study it was necessary to gain ethical approval from the local NHS research ethics committee. This committee act as gatekeepers to those requesting access to NHS patients and staff, as without their approval the study would not go ahead. The application process required me to consider all aspects of the research, with particular regard to the protection of the participants and of myself as researcher. Ethical approval was granted, based on my original proposal, allowing me to proceed with the study.

### **4.3 The research participants: Access, recruitment and sample size**

#### *4.3.1 The research site: The acute ward*

The physical and cultural environment of the acute ward was integral to the experience of the participants. As I visited the ward I observed the environment and the interactions of its inhabitants, noting these in my fieldwork journal. These visits took place between Monday and Friday and were generally between the hours of 9am and 4pm. Thus my observations of the ward are not based on experience of the whole 24-hour cycle of care. However, despite this limitation, these observations help illuminate the cultural context of the ward.

The acute ward was part of a large psychiatric hospital situated outwith the major Scottish cities. Set in its own grounds, there were recreational facilities including a separate shop/café, gym and occupational therapy centre. Much of the grounds were parkland with some mature trees, providing space for participants to walk.

The ward itself was housed on one floor, with single-sex six-bedded dormitories and several single rooms. Each dormitory had a large window looking out over the grounds, and a couple of comfortable chairs and small table next to this window. The beds were spaced out along the walls, each with its own curtain screen. The dormitories were down one end of the central corridor, at the other end of which were the lounge/TV room, dining room and smoking room. The smoking room had a large window through which patients could watch people entering and leaving the ward. A small room with few pictures and seats arranged round the walls, the smoking room was always occupied when I visited the ward.

The ward was staffed by a team of nurses of varying grades. Some of the nursing staff worked on nights only, and some on days only. Medical responsibility for patient care was undertaken by one of the three consultant psychiatrists who operated within the ward. Each consultant had junior medical staff working under his or her supervision. There was also input from specialist professions such as Social Work and Psychology on the ward.

The nursing office was situated halfway down the corridor that connected the sleeping and social areas. Recessed slightly from the corridor, I observed that there were

always nurses in the office, usually writing, on the phone or chatting. The door was often closed and it was difficult to know if the voices that could be heard from within indicated that there was a meeting going on or were just nurses chatting. When confronted by the closed door I felt anxious, not wanting to interrupt something important when I knocked and asked for attention. The following excerpt from my fieldwork journal highlights how the office door could be perceived as a barrier:

*“On returning to the nurses’ office between informal meetings [to introduce the research to patients] I find the door is closed. I feel anxious and don’t know whether to knock and go in. A patient walks past, ‘just knock and go in’ he says. Even as a professional the closed door is inhibiting; how does that feel for the patients?”*

Extract from field work journal 15 June 2006

There was a desk situated outside the nursing office and on several occasions I observed several members of the nursing staff hanging about round this, or leaning against the wall in the corridor. The following extracts from my fieldwork journal capture this scene:

*“I realise quickly that it is handover as there is a cluster of nursing staff and students at the desk outside the nurses’ office [handover takes place inside the nurses’ office and the door is closed]. An older male staff nurse kind of looks at me questioningly and I introduce myself and tell him I am the researcher he may have heard about. I sit down in the chair at the desk. He sits on the desk and the other three female nurses (including two students) and male student nurse stand leaning against the walls. My presence is ignored and they carry on chatting. A patient walks past obviously looking for someone. No one approaches her and asks her if she wants help. She pauses on the edge of the crowd and then plucks up the courage to ask if it is handover just now. Male student nurse tells her ‘yes’ and suggests she come back later. The chat between staff is resumed.”*

Extract from field work journal, 15 June 2006

*“After chatting [to patient about participation in research] went back to nurses’ office to find staff nurse at desk reading a novel.”*

Extract from field work journal, 21 June 2006

Generally when I attended the ward it appeared busy, with nurses constantly being required to answer phone calls, deal with patients knocking on the office door, deal with requests from other professionals within the multidisciplinary team, or fill out paperwork.

*“Appears to be just as chaotic – staff writing notes, doing discharges. A doctor appears on the ward to sign section papers – Charge Nurse unable to locate them as one of the staff nurses who has gone chasing after a patient had got them out. Charge nurse and staff nurse both feeling run off their feet. Staff Nurse tells me they’re short staffed.”*

Extract from field work journal, 26 May 2006

On one occasion, whilst crossing the car park to the entrance to the ward, a patient stopped me. She informed me that there was a patient behaving aggressively on the ward, throwing chairs, and indicated that this made her feel too vulnerable to remain on the ward. Although the aggressive behaviour had subsided by the time I entered the ward, my notes indicate that I sensed the situation remained volatile:

*“I enter the ward and find that the aggression must have calmed a bit, and I see a young man being escorted about the ward by staff. Whilst in his room staff sit outside and the two staff members converse. This obviously upsets the man as he appears to become paranoid that they are talking about him. The staff member reassures him that they are not talking about him, stating that if it was anything to do with him (the patient) he [the staff member] would address him directly.”*

Extract from field work journal, 30 June 2006

At other times when I visited the ward it appeared quieter:

*“Commented to staff nurse how quiet it was (only 11 beds filled). She agreed and said it’s hard to know what to do with yourself because the patients didn’t want the company. Discussed with her colleague that they planned to get on with jobs needing done; practical tasks around the ward.”*

Extract from field work journal, 29 June 2006

*“It all seems quiet today, and staff on duty seem quite relaxed. Chat with F-grade [charge nurse] about her research work...”*

Extract from field work journal, 6 October 2006

My observations of the ward environment offer an image of separation between staff and patients created by closed doors and the tendency of staff to stand and chat in the corridor. The atmosphere was one of busy-ness interspersed with some quieter periods.

#### 4.3.2 *Developing an access strategy*

The research required access to a small number of people who had experience of being on the acute ward. Making contact with potential participants through

Community Psychiatric Nurses (CPN) or mental health projects within the voluntary sector was considered. These strategies were discarded for the following reasons. Firstly, there was no means of controlling for length of time since admission to the acute ward, thus it was anticipated that some participants might have been patients on the acute ward recently, whilst for others, admission might be in the distant past. Secondly, it was anticipated that recruitment through the CPNs or voluntary sector would require a lot of involvement from workers to set up meetings, and thus it would be more difficult to keep people's participation in the research confidential.

The strategy adopted involved recruitment of participants whilst they were patients on the acute ward, because it offered a number of benefits in comparison to the above strategies. Firstly, this strategy offered the opportunity to recruit participants from the entire acute inpatient population, whereas, many patients are discharged from the acute ward with no CPN or voluntary agency support and would therefore be lost to the study. Secondly, there was also better scope for maintaining confidentiality regarding participation, because the ward staff were only involved in initial introductions, not in arranging interviews.

Approaching people about participation whilst patients on the acute ward was also anticipated to increase the likelihood that they would agree to take part, because issues pertaining to their stay on the acute ward were pertinent at that point in time. I hypothesised that as people become more distant from the point of their admission they might become less likely to agree to talk about it, particularly if it would give rise to difficult emotions and issues that they had attempted to put behind them. This issue arose on two occasions whilst I was recruiting participants: one gentleman had agreed to take part in the study but then contacted me to tell me that having considered it further he just wished to move on after discharge; another patient I met raised several issues that she felt ought to be included in the research, but did not wish to take part because she wanted to forget about the admission and get on with her life once discharged.

Recruitment of participants whilst they were still patients on the acute ward also allowed me to give some uniformity to the period of time between discharge and

interview. I was therefore able to develop a protocol that would allow me to interview all participants at two and six weeks post-discharge.

Despite the impression that this protocol is a means of standardising issues of memory, the impact of time on memory is unknown, and is likely to be unique. The period between discharge and interview would be a time when participants develop their stories about being a patient on the acute ward. These stories would undoubtedly be influenced by factors such as previous knowledge and experience, others' reactions to their admission, and their sense of identity. Thus, the standardisation of interval between discharge and interviews was more a practical consideration than a means of creating a rigorous design.

A final benefit of approaching potential participants whilst they were on the acute ward was perceived to be the opportunity to meet with them and explain the study before they were discharged. It was anticipated that the opportunity to meet with me face-to-face would dispel some of the anxieties that may arise from being asked to participate in a study by somebody they had never met, and would facilitate choices about participation.

Despite the potential benefits of accessing participants through the acute ward there were also potential pitfalls. In particular, there was the danger that the participants might see me as associated with the hospital or the staff team. This would influence what participants were prepared to discuss with me for fear that it might have implications for any future admissions to the ward.

#### *4.3.3 The role of ward staff in recruiting participants*

The charge nurses on the acute ward were contacted early in the process of application for ethical and management approval. Discussions about the best means to carry out recruitment allowed them to express their concerns, and for me to develop my approach in a manner that would cause least disruption on the ward, and least anxiety to staff. The agreed approach gave ward staff a gatekeeping role, as they retained the power over whom I could approach for the purposes of introducing the study. The assignation of the gatekeeping role to the staff was done on ethical grounds, protecting patients who were too acutely ill to be approached about



participation. Further, the staff team's clinical risk assessment was used to exclude those who posed a significant risk to me as researcher.

My reliance on the ward staff to enable me to access potential participants raised the issue of getting the staff on my side. Resistance to the research and my presence around the ward was a potential obstacle to successfully recruiting participants. I therefore prioritised the need to inform staff about the aims and process of the research, and dispel any anxieties they might have about the implications for them. A leaflet explaining the study was developed and distributed to the ward staff (see appendix 2), and a short briefing held to enable them to ask questions. Initially I detected a degree of anxiety about the study, and there were a number of comments from staff that led me to believe that they felt that it was their nursing activities that were to be scrutinised and evaluated by patients. Staff were assured that the focus of the study was on the patient's expression of their experience, and that this was likely to include a wide range of topics only some of which, it was anticipated, would relate directly to nursing practice. Throughout the recruitment process I was available to answer any queries the staff had regarding the study.

As well as informing staff about the study, I visited the independent advocacy worker who was based within the hospital. I explained the study and that I felt it was necessary to have somebody who was independent with whom potential participants could discuss any anxieties they might have about what participating in a study might mean for them. He agreed to be a named contact for any such patient, and his contact details were printed on the participant information leaflet. To my knowledge none of the participants used this facility.

Throughout the time that I was attending the ward I found the staff helpful. Some were organised and drew up lists of potential candidates prior to my arrival on the ward. However, there were occasions when the ward appeared busy and chaotic, and I felt my presence created an additional burden for the staff.

The involvement of the ward staff in a gatekeeping role had the potential to influence the research in a number of ways. Firstly, they may only offer access to patients whom they judged would be suitable, or give good account of their experience. This

issue arose in conversation with staff on several occasions, where their discussions of whom I should approach were littered with phrases implying judgements about patients' willingness, competence, articulateness and general suitability for participation. On these occasions it was necessary for me to reiterate clearly my inclusion criteria in the hope of countering the effect of some of these judgements. However, it must be acknowledged that access to potential participants will have been influenced by the nursing staff's value judgements regarding suitability:

*"They flap about saying they don't know who would be suitable – I reiterate my recruitment criteria. Comments such as "oh, he wouldn't engage" follow the consideration of several names. I try to assure them that I am really wanting to see anybody who is nearing discharge and who does not fall in the exclusion criteria, and they can choose whether to engage."*

(Excerpt from field work journal, 6 September 2006)

Ward staff were not only responsible for choosing whom I would approach, but were also often involved in introducing me to patients. Being introduced to potential participants by the staff was generally more effective in gaining me the opportunity to discuss the study than me approaching patients myself. The nurses' willingness to introduce me was possibly experienced by patients as a validation of my presence, and the patients' willingness to speak to me indicative of their trust in the nurses.

The manner in which the nurses introduced me to the patients influenced their willingness to meet and allow me to explain the study. Nurses who displayed enthusiasm for the study tended to arouse the patient's interest, and increase the likelihood of their agreeing to let me introduce the study to them. However, this enthusiasm could verge on coercion, raising ethical concerns, as highlighted in the following excerpt from my fieldwork journal:

*"My discussions with people today are heavily influenced by my desire to emphasise the voluntariness of participation. I feel very uncomfortable about the nurse's introductions; indicating to people that she is aware that they have ideas about the ward and that by participating they can help others."*

(15 June 2006)

The recruitment strategy opened up the possibility that participants might feel coerced by staff to take part. This became a concern when witnessing one of the staff telling patients that they should take part because she knew they had points they wanted to

make. Several strategies were employed within the research to try to ensure that participation was voluntary. Firstly, the involvement of ward staff was restricted to initial introductions to potential participants. Whilst these participants may have agreed to meet with me to discuss the study in order to please the nurses, participation in the study did not begin until the first interview at least two weeks later. During this period potential participants had time to reflect on whether they wished to participate. Secondly, I did not ask potential participants to consent to participation when I met with them initially. Formal written consent was only requested at the beginning of the first interview; issues of participation and consent were discussed before the form was signed, and then again at the second interview. Potential participants were informed of the possibility of withdrawing from the research at any time, without having to give a reason why. This right to withdraw was stated in the information leaflet that participants received. The two withdrawals from participation before the first interview might be assumed to indicate that people felt able to withdraw their verbal consent to participate (Davies, 2005).

A further potentially influential aspect of being introduced by the nursing staff was that the patients would then consider me to be one of them. I became a regular face on the ward, particularly when waiting outside the office to talk with the nurses. It was therefore necessary for me to make my independence as a researcher explicit when I discussed the study with potential participants.

Whilst often the nursing staff would introduce me to the patients they were not present whilst I explained the study and what participation would entail. These discussions took place in one of the interview rooms in the back of the ward, and were confidential.

#### *4.3.4 Introducing the study to potential participants*

One of the benefits of accessing participants through the acute ward was the opportunity to meet with potential participants and introduce myself and the study. The introductory sessions on the ward were used to give potential participants the written information leaflet about the study (see appendix 3). Topics such as confidentiality, anonymity, consent, the aim of the study, data protection, and the form of the interviews were discussed and any questions answered. It was anticipated

that the leaflet and discussion would provide the potential participant with the basic information required to facilitate an informed decision about consent, without overburdening them (O'Neill, 2003).

The information booklet contained contact numbers for participants to get more information about the study, or examine their concerns about participation. In this way I tried to ensure that consent was based upon the amount of information that each participant felt they needed to be able to make a decision about participation. Despite these efforts, I acknowledge that consent was based only on partial knowledge of what participation would entail for each participant.

During the introductory meetings I discussed my motives for undertaking the study, and my background as a psychiatric nurse. Despite my concerns about how this information would shape what participants were able to disclose to me in their narratives, I felt that a relationship that did not acknowledge these pertinent aspects of my identity could not be considered as honest. When considering O'Neill's (2003) definition of informed consent, such a relationship might be experienced as deceitful, and thus informed consent rescinded.

Patients were not asked to verbally consent to participation at this point, but instead were encouraged to think about the possible impact of participation for them, and their significant others, over the next few days. The patient information leaflet contained the number of the independent advocacy worker, based within the hospital, who had agreed to discuss any worries that patients might have about participating. Patients were also able to contact me, or speak to the staff, about any queries they might have. They were informed that I would be visiting the ward a few days later, and that I would hope to catch up with them then to find out whether they wanted to take part. In the event of someone being introduced to the study when they were close to discharge, I asked for their written consent to contact them in the event that they were discharged before I found out whether they wished to participate.

In order to maintain confidentiality pertaining to participation in the study, ward staff were not informed about who had agreed to take part.

#### 4.3.5 *Becoming a familiar face on the ward*

I attended the ward regularly during the fieldwork period in order to be introduced to potential participants. Spending time on the ward, often hanging around waiting to catch hold of staff, meant that many of the faces became familiar. Patients whom I recognised would say 'hello', or stop to chat. Through these brief interactions I began to form relationships with some of the patients, many of whom went on to participate in the study. One particular incident highlighted to me the impact of becoming a familiar face on my relations with patients:

*"As I walk along the corridor I bump into B ...tells me she is going on pass. We chat about previous pass outings and her imminent pass and what she plans to do whilst out. As we talk about this and her cat we wander along toward her room. There we sit and chat and B tells me about playing the guitar and her song writing. She then volunteers to play a song that she wrote, to me. I felt privileged to have her chat to me like this and sing her song to me; our previous interactions had been brief and lacking in any warmth."*

(extract from field journal, 11 June 2006)

The initial interactions with participants whilst they were on the ward began the process of relationship formation, and in particular the development of a rapport. I can only hypothesise that having personalised the research relationship strengthened individuals' commitment to participate. Thus, the level of attrition in the study was low, with only two people who had initially agreed to participate, not taking part. However, whilst the formation of a tentative relationship with potential participants might increase participation, there was a need to ensure that participation was voluntary, and consent freely given.

The other effect of having already begun to develop a relationship with participants prior to interviewing them was the high level of disclosure within their first interviews. Participants offered stories layered with emotion and detail about their experiences, indicating a sense of relationship beyond the purely superficial. Many referred back to issues we had discussed when I had met with them initially on the acute ward. The relationship was clearly perceived as developing from the point of our initial meeting.

#### *4.3.6 Sample size*

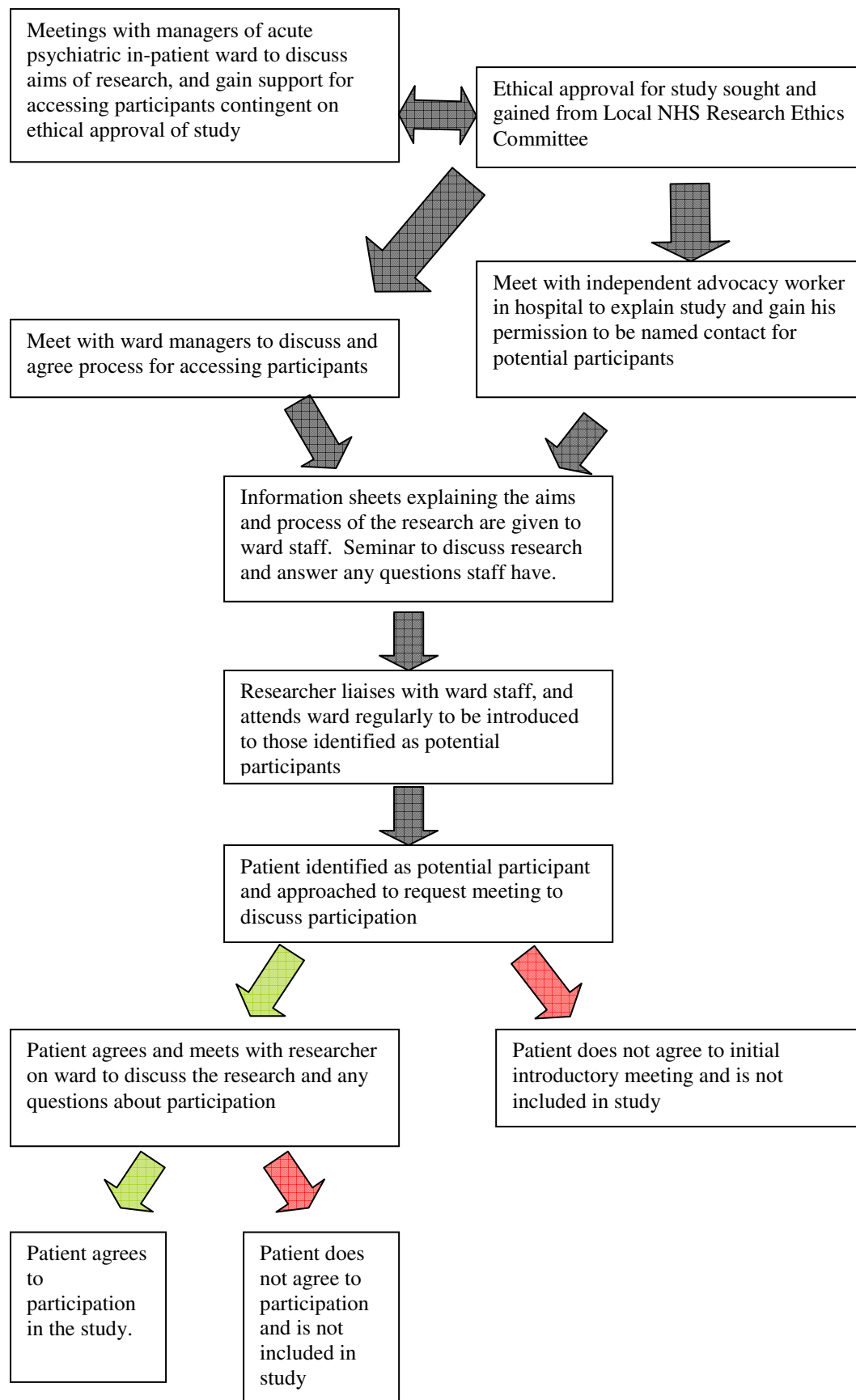
There is no hard and fast rule regarding sample size for qualitative research. Morse (2000) considers sample size as a function of the type of study, the nature of the topic on which it focuses, and data collection methods in terms of how much data is likely to be generated. She suggests that for a study where large amounts of data are generated for each participant the sample need only be six to ten participants. Taking into account the expectation that the unstructured interviews would lead to large amounts of data, and the fact that each participant would be interviewed twice, the intended sample size in this study was ten to fifteen participants.

A total of thirteen people participated in the research: seven women and six men aged between 18 and 65 years. All participants were patients on an acute ward in Scotland during the period May to October 2006. All spoke English as their first language. Participants were self-selecting, and had a range of diagnoses, longevity of problems, and numbers of admissions to psychiatric hospital.

For the protection of participants and researcher, a number of exclusion criteria operated during the recruitment phase. Patients who were assessed by the staff or researcher as lacking the capacity to give informed consent could not be included. Further, patients who were assessed by the responsible medical officer, nursing staff or the researcher as posing a serious risk of harm to the researcher were not included. Several patients were excluded from participation because ward staff assessed that they posed a significant risk to researcher safety.

During the recruitment phase, nobody was excluded because they lacked the capacity to consent. It may be, as Davies (2005) concluded in her study, that this was a function of the ward staff's judgements regarding capacity when recommending potential participants. It may also reflect the fact that participants were recruited towards the end of their stay, thus they were no longer in the acute phase of their illness and were, therefore, considered as having the capacity to make decisions about consent.

Figure 4.3: Diagrammatic representation of the process of accessing and recruiting the research participants



## **4.4 Eliciting and gathering narratives: The data collection method and strategy**

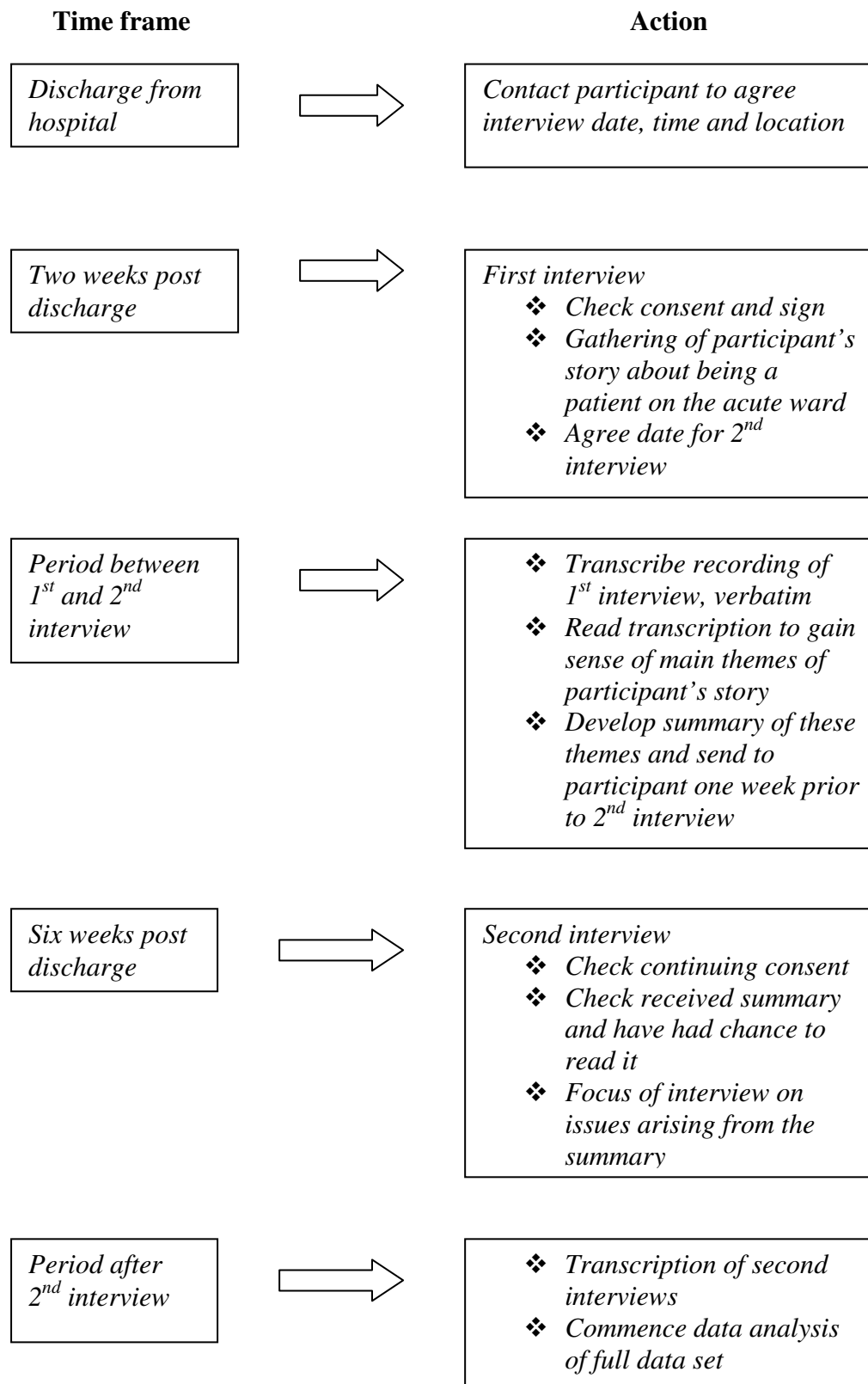
### *4.4.1 Introduction*

The study aimed to explore participants' experiences as represented within their narratives. The data collection method therefore needed to facilitate the telling of narratives. Given the assumption that narratives are linguistic representations of experience, and that narrators construct their narratives in a manner that allows them to convey what they mean [see Chapter Three], then the data collection method also needed to allow participants to tell their narratives in the way that they chose, using their own language. The chosen data collection method and strategy also had to uphold the ethical principles described at the beginning of the chapter. In this section I discuss the rationale pertaining to the choice of method and strategy

Unstructured interviews were chosen as the data collection method, and the data collection strategy involved participants being interviewed twice, two and six weeks post discharge. Interviews took place at home. Participants consented to the digital recording of their interviews. Figure 4.4 provides a summary of the data collection strategy.



Figure 4.4: Summary of the data collection strategy



#### 4.4.2 *Unstructured interviews as a data collection method*

4.4.2a *What are unstructured interviews?:* The unstructured interview is one where the interviewer has no preconceived agenda of questions or topics that will be covered within the interview. Instead, the interviewer introduces the interview topic using a broad statement from which the interviewee is encouraged to develop his or her response in the manner they feel most appropriate. In the study, I began the first interviews with the same broad statement:

*“Me: okay, so, like I said to you when I saw you before, really what I’m looking for is just to gather people’s stories of what it’s like being in (acute) ward. Okay. And it’s your story so you can start where you want to and include what you want.”*

Jill, interview 1

The interviewer adopts the position of active listener, whose interjections arise from the interviewee’s narratives (Rosenthal, 2003). Thus, the material covered in such interviews can be diverse, as the researcher approaches the interview with an open mind, and does not restrict the interviewee to a narrow agenda. This approach to interviewing is likely to elicit narratives, as the interviewee is encouraged to develop his/her response in line with his/her own views and is not pulled back to the narrow concerns of the interviewer.

The development of narratives in unstructured interviews is dependent on the relationship that develops between participant and researcher. The researcher’s response to the participant, and the participants’ perceptions of the researcher will facilitate or close down narratives. The research relationship therefore becomes central to data collection.

4.4.2b *The participant controls the agenda:* As described in the above section, the interviewer’s input in the unstructured interview stems from the content of the interviewee’s narrative. Thus, whilst the interviewer influences the development of the narrative during the interview, this influence is restricted to the topics already raised by the interviewee. The interviewee can therefore be described as having control of the agenda in terms of controlling what topics are discussed. The narrative is therefore structured by the participant; developed from within their frame

of reference, using their language. Participants are also able to close down or avoid topics that they do not wish to discuss.

*4.4.2bi Working from within the participant's frame of reference:* During the study, the first interviews with each participant were characterised by the participant holding the floor for long periods of time, with minimal interruption from myself apart from non-lexical utterances indicating that I was listening and that the participant should continue his/her story. Reflective statements and more direct requests for clarification were used where appropriate to ensure that I was hearing the participants' story. In several interviews the participant held the floor until they indicated that they had reached the end of their account. This was signified by a statement such as, *'I think that's all I can tell you'*. It was after this phase that I was then invited to ask any questions about their story.

It is in this way, through researcher intervention that is guided by the participant's narrative, that unstructured interviewing facilitates the development of narrative using the narrator's structure. In Chapter Three I discussed the link between narrative structure and narrative meaning. Within this study it is assumed that a narrative whose structure is developed by the narrator, in accordance with his need to convey meaning, will come closer to conveying the meaning of the narrator's experience than a narrative that has its structure dictated by another person.

If our experience **is** our account of events (Frank, 1995), then it follows that the language used in giving that account is pivotal to knowing that experience (Thomas & Pollio, 2002). Thus, if the aim of the research is to know others' experiences then the research must acknowledge the primacy of language. In this respect, the chosen method of data collection must respect the importance of the participants' language use.

Throughout the interviews I adopted a conversational tone, avoiding professional jargon. At times, participants would express their understanding of their situation through use of particular phrases. When appropriate during the interviews I sometimes used the participants' phrases. For instance, in her first interview Joanne refers to her experience of the lack of structure on the ward as *"you potter about all*

day”. During my second interview with Joanne, we discuss her sense that she is no better able to cope now having spent time in hospital. During the following exchange I use Joanne’s phrase “*pottering about*” as I refer to how she had evaluated her time on the ward:

*“Joanne: So I’ve got to follow that up [referral to Community Psychiatric Nurse] and cos I ken I still haven’t got the support and things, I still feel I cannae cope*

*Me: yeah, yeah. Well it kind of just then leaves you, all it leaves you is the option of either being here trying to cope by yourself, or in the hospital ward pottering about*

*Joanne: I’d rather be here*

Joanne, interview 2

However, so as not to make assumptions that I knew what the participant was referring to, I commonly reflected back my understanding of the phrase they used. In his interviews Ewan expresses his understanding of his illness in terms of his “*level*”.

*“Ewan: I was glad that last time that I realised myself that there was something up, when your level goes off. And two times before I’ve sort of, sort of tried to just finish it, ken?...cos when your level goes off you just havnae got any control...*

*Me: right, so you just become really low in mood and start to feel really down?*

*Ewan: that’s it, and that’s where, well I’ve never done it like, but that’s where a lot of them self-harm, like.*

Thus, during the interviews I indicated my respect for the participants’ use of language through my conversational tone, and non-jargonistic speech. Where participants adopted a particular phrase to refer to concepts that were central to their narratives I would use this where appropriate. However, in doing so I was mindful of the need to check that my interpretation of such phrases related to the participants’ intended meaning.

4.4.2bii *Preventing over-disclosure:* There is a fine line between gathering rich data, and encouraging the disclosure of information that may be experienced as exploitative by the participant. The ethical principles pertaining to

research demand that participants be protected from harm (Dench *et al*, 2004). Such harm can be caused by over-disclosure where a participant reveals more than he/she would usually feel safe enough to do.

Control of the agenda within the interview is implicated in the power relations between researcher and participant. An interview process that allows the participant to take control of the agenda, and structure his or her narratives as they wish, is assumed to be empowering (Corbin & Morse, 2003). The ability to choose whether, and how, to tell their story (Corbin & Morse, 2003; Enosh & Buchbinder, 2005) offers participants some degree of protection as it allows them to avoid or close down issues that they do not wish to discuss (Rosenthal, 2003). During the interviews I allowed the participants to take the lead in raising particular issues. The depth of exploration of the issues raised was dictated by the participants' verbal and non-verbal cues. In this way, participants were able to control the topics that were covered, and the depth to which they were explored.

Throughout, the researcher must remain sensitive to participants' cues indicating that a particular topic is closed. In the study, some participants made this explicit by stating '*I don't want to go there*' (Becky), whilst others relied on non-verbal cues such as hesitations, eye contact or postural indicators. By allowing the participant to take the lead in the interviews, the closure or avoidance of topics that the participant did not wish to discuss was facilitated. This afforded participants some protection from over-disclosure.

*4.4.2c Valuing people's experiences by giving them permission to talk:* Participants narrated their experiences in the context of discourses pertaining to mental health and illness. Whilst changing cultural attitudes to mental health, and the development of new social movements such as the users movement, have increased the acceptability of talking about mental health issues, there remains a stigma attached to such stories (Plummer, 1995). Telling stories about mental health problems and hospitalisation may stir up difficult emotions for participants that require sensitive handling, yet the interview may provide the environment to permit people to talk about issues that are taboo.

Several authors recognise the benefits for participants of being allowed to talk about their experiences (Collins, 1998; Rosenthal, 2003; Corbin & Morse, 2001; Murray, 2003; Gair, 2002). At the end of the second interviews I discussed with participants their experience of participating in the study. Many talked about the positive aspects of being allowed to articulate their experiences to someone who was willing to listen and showed a desire to understand what it meant for them.

In his study of local authority workers, Collins (1998) noted that his participants talked to him about things that they didn't talk to others about. When interviewing Jill I was struck by a sense that it was extremely difficult for her to talk about the deeper emotional aspects of her experience. I reflected this sense to her. This opened up a dialogue in which she told me that she did not talk about the detail of the experience, keeping any discussion she had at a superficial level; even with others with whom she had been on the ward and kept in touch. She sensed the guilt experienced by her family when reminded of her admission to hospital, and so did not talk with them about it. The stigma she associated with admission prevented her talking with her peers about it; many of them did not know she had been in hospital. Jill obviously found it distressing to talk about her experience, but seemed to gain from being allowed to articulate her story to someone who was not part of her everyday life. As such, the interviews provided a space for Jill to talk and make sense of her experience.

Frank (1995) considers that what participants are wanting from those to whom they tell their stories, is that they bear witness to their testimony. It is as if being permitted to talk, and having painful stories attended to, allows participants to experience a connectedness with others through sharing their experiences with those who do not have that experience (Rosenthal, 2003).

*4.4.2ci Support for participants:* Recounting and reflecting on the meaning of their experiences raised the possibility of bringing emotional issues to the fore, with which participants might struggle to deal (Shaw, 2003). This does not necessarily mean that the interview is harmful (Rosenthal, 2003; Corbin & Morse, 2003; Dench *et al*, 2004), but some authors have found it useful to have a list of resources to hand as a way of offering somewhere for participants to go to work

through any issues following an interview (Ensign, 2003; Owen, 2001; Corbin & Morse, 2003). At the end of the first interview I gave participants a list of agencies that were aware of my research, and that they could contact should they wish support.

#### *4.4.3 The research relationship*

*4.4.3a Researcher qualities and skills:* The research approach places the interaction of researcher and participant at the centre of the research process. In order to encourage participants to tell their narratives they need to feel safe to do so, and this is contingent on the research relationship (Miller & Glassner, 1997; Thomas & Pollio, 2002; Riley *et al.*, 2003; Hollway & Jefferson, 2000). Qualities such as trust and rapport are built as the participant experiences the reactions of the interviewer to their narratives. As participants gain a sense that they will not be judged, and that their thoughts and opinions are valued and respected, they feel more secure in the relationship (Rosenthal, 2003; Riley *et al.*, 2003; Hollway & Jefferson, 2000; Miller & Glassner, 1997). The use of such person-centred counselling skills as active listening and reflection convey to the participant the interviewer's interest in, and desire to hear and understand, what they say (Rosenthal, 2003; Rogers, 1951).

During the interviews I drew heavily upon my counselling skills and experience as I listened to participants and responded to their narratives. Attending to my own body language – posture, tone of voice, eye contact, and positioning in relation to the participant – I signalled my interest in, and empathy with, the participants' experiences. By remaining sensitive to the non-verbal aspects of participants' communication, I was able to access the emotional aspect of their narratives, as well as identify invitations to explore a particular topic further or to close down others.

Counselling skills such as summarising and reflective statements enabled me to increase the richness of the narratives that were told. Through these actions I indicated my interest and desire to hear and empathise with the participants, building rapport. The following excerpt from Becky's first interview shows how my reflective statement is used to check out that I have understood what she is saying, and encourages her to elaborate:

*“Becky: I do know what caused the illness, and what, em, its’ still there, the illness is still there, you have to learn to surf it. You have to learn to surf the thoughts and you just don’t walk away and it’s all gone, this is something you learn to do in the hospital. You learn to internalise stuff which you don’t really want everybody to know you’re thinking*

*Me: right, so you begin to show what you, you filter what you show and what you don’t show then in terms of what you’re thinking*

*Becky: yes, yeah, and instead of being completely open and transparent you then become more within yourself, and if you’re still having those thoughts, once you can remove the, em, once you can, once you don’t let on what’s going through your head all the time by either your body language or what you say then you really have got it.”*

Becky interview 1

*4.4.3b Consent and confidentiality as a facet of a trusting relationship:* For the development of trust and rapport as discussed above, it is necessary for the participant to have freely consented to participation, and to be aware of the meaning and limits to confidentiality within the research relationship. Consent was conceptualised as a process rather than a one-off bureaucratic necessity. Issues pertaining to consent were discussed at the beginning of both interviews, with written consent (see appendix 4) being obtained at the beginning of the first interview. Participants were reminded that they could withdraw their consent at any time they wished.

To facilitate the development of trust in the research relationship, confidentiality and its limits were discussed. The research relationship was premised upon the understanding that participation would remain confidential. Indeed, participants were asked during the consent process if they wished me to let anybody know that they were participating in the study. In the interests of maintaining an honest relationship, I discussed the limitations to maintaining this confidentiality. These limitations stemmed primarily from my dual status as psychiatric nurse and researcher; my obligations under child protection law, and my duty of care. Discussion of these limitations allowed participants to make informed choices about what they disclosed (Price, 2002).

*4.4.3c Researching patients’ experiences as a nurse:* The theoretical stance of the research embraces the influence of the subjectivities of both researcher and



participants, viewing them as an integral part of attempts to understand social phenomena. The research relationship was central to data collection, and issues of subjectivity were inextricably linked to the narratives generated as data within the interviews. However, it is not possible to anticipate the aspects of one-self that will be influential in any particular relationship (Reinharz, 1997; Collins, 1998).

I felt that my status as a psychiatric nurse was a part of my self that needed to be made explicit to the participants because I was researching the experiences of patients. Similarly, Bar-On (1996) made his identity as a Jew explicit when interviewing children of Nazi perpetrators. Although Bar-On anticipated that knowledge of this part of his identity might be problematic within his research relationships, he did not experience it as such.

My reasons for making my psychiatric nurse training explicit were bound up with O'Neill's (2003) notion that to achieve informed consent, the participant must not experience the research as deceitful. By not making my identity as a psychiatric nurse explicit, I could be perceived to be attempting to hide a pertinent part of my self. Such premeditated action could be perceived by participants as an attempt to deceive. I therefore decided that, to be able to develop honest relationships with participants, I would make my identity as a psychiatric nurse explicit, thus avoiding the possibility that participants would experience the research relationship as deceitful. However, whilst it felt like a necessary part of the research process, it was not possible to predict, nor determine, the impact of this knowledge on my relationships with participants.

I was concerned that participants' previous experiences of relating to psychiatric nurses would create expectations of their relationship with me. Implicit within these expectations were ideas regarding power relations, the balance of power within the nurse-patient relationship being traditionally held by the nurse (cf. Davies, 2005; Barnes & Bowl, 2001). Would this traditional power relation be enacted within the interviews, and close down participants' narratives?

This issue was encountered by Gair (2002), a social worker carrying out research which involved clients' experiences of the social work services. She found that

despite knowing that she was a social worker, participants openly voiced their negative opinions about the profession. She concluded that participants felt empowered by being offered the opportunity to discuss their dissatisfaction with a member of the profession with which they were dissatisfied. During my interviews with participants many made critical comments, particularly regarding their relationships with nurses. It would therefore seem that, for some at least, my background as psychiatric nurse did not close down these stories.

A further expectation engendered by participants' previous experience of the nurse-patient relationship was that it would be therapeutically oriented. Thus, participants may tell their stories in a manner that designed to invoke a therapeutic response (Ensign, 2003). This was not only an issue for participants. My own experience of nurse-patient relationships is heavily inscribed with therapeutic expectation.

When conceptualising the interview process I considered it desirable to ensure that I did not slip into 'therapy mode'. This process, termed 'bracketing' by some authors, requires the shutting off of the therapeutic side of the nurse in order to remain in the role of the researcher (Ensign, 2003). In reality, my desire to remain authentic within the interviews did not allow me to 'bracket' aspects of my self, even if this were physically possible. In many ways the interview style ran close to that of a therapeutic interview, as I drew upon my skills developed as a psychiatric nurse. Like Ensign (2003) I found it impossible to avoid slipping into the nurse role in response to some aspect of the participant's story.

A further concern regarding participants' knowledge of my psychiatric nurse background was that there may be suspicion regarding my motives, and ability, to represent their experiences as patients. The medical tradition, to which nursing is allied, has a history of privileging professional knowledge over patient/service user knowledge (Davies, 2005; Barnes & Bowl, 2001; Beresford & Wallcraft, 1997). When meeting patients on the ward to discuss potential participation in the study I informed them as part of my prepared information about my motives for undertaking the study. Before and after the interviews participants often wanted to discuss these motives, indicating that this was something that mattered to them.

Finally, it was possible that participants might perceive that I was not sensitive to their issues. In order to represent the patients' experiences, it was necessary to attend to the issues that they perceived as important. As a nurse I brought knowledge gained from the nurse's perspective to the research, sensitised to nursing rather than patient issues. Throughout the interviews my interventions were grounded in the participant's story and were used for the purposes of gaining clarity. In this way I attempted to overcome the tendency to assume that I knew what participants meant based on my own knowledge and experience.

#### *4.4.4 The two interview strategy*

Each participant was interviewed twice, with two exceptions: Jennie stated at the first interview that she did not want a second interview; Connor was not available when I attended for the second interview, and did not contact me when invited to reschedule. The development of a strategy where participants were interviewed twice facilitated the development of the research relationship, and thus the gathering of rich data. It also allowed participants to become more involved in the analysis of their narratives should they wish, as well as allowing me to check out that I had understood what they were trying to tell me.

*4.4.4a Developing the relationship:* The two-interview strategy was developed in order to facilitate the development of the research relationship, as it was anticipated that trust and rapport would strengthen over time, and thus when we met for the second interview the participants would feel more able to discuss deeper issues. Like Hollway and Jefferson (2000) I found that during the second interviews there was often an increase in the intimacy of the detail disclosed.

*4.4.4b Checking out my understanding and increasing participant involvement:* The process of carrying out two interviews also enabled me to offer participants the opportunity to participate in the analysis of their narratives. Prior to the second interviews, the first interviews were transcribed and read to draw out the main themes. These themes were summarised and sent to the participants one week prior to the second interview. They formed the basis of discussion in the second interview, enabling me to check out my understanding and interpretation of their story. Such involvement of participants in the data analysis process was intended to indicate to

them that I wanted to get as close as possible to understanding the meaning conveyed in their narratives. In this way I hoped to indicate to participants the respect that I had for them as people with something of value to offer.

#### *4.4.5 Location of interviews*

The location of the interviews had the potential to open up or close down narratives depending on how safe the participants felt (Holstein & Gubrium, 1997). It was anticipated that if participants felt comfortable in the environment in which they were interviewed then they would be more able to give in-depth accounts of their experiences (Green & Hart, 1999). Due to the anticipated difficulties in creating a safe space for participants to talk freely, interviews were not conducted within the hospital boundary. Participants were asked where they wished to be interviewed; all chose to be interviewed at home.

Interviewing participants in their own homes placed me in the role of ‘guest’, and the participant in the more powerful position of ‘host’, upholding my desire to reduce the power differential in the research relationship. It also gave participants the opportunity to opt out, for example by not answering the door, or by being out. Participants were no longer under the influence of hospital staff, and could choose whether or not they would keep the interview appointment.

However, the anticipated benefits of interviewing participants in their homes had to be balanced with the risks to me as a researcher, requiring the development of risk assessment and safety protocols.

*4.4.5a Researcher safety:* My decision to interview participants in their own homes raised anxiety about researcher safety. The reactions of fellow post-graduate students, the local NHS ethics committee, and the police with whom I discussed my intentions to interview people at home all seemed to be underpinned by the view that people with mental illness are dangerous. I experienced these views as unsettling because they conflicted with my own view that people with mental illness pose no more risk than the general public. Yet these views were voiced by people in authority, and so could not be easily dismissed. I was methodologically committed to

interviewing in people's homes, so I proceeded by developing a safety protocol to address potential dangers.

The safety protocol that I adopted was drawn from my previous experience working as a Community Psychiatric Nurse. It stated that I would leave contact details of my visit with one of my supervisors, and details of the time of the interview. When the interview was complete and I had left the participant's house I would contact my supervisor. A two hour time limit was set, that if I did not contact my supervisor within two hours of beginning an interview then she would try and contact me on my mobile phone, and if she got no reply, would contact the police. This protocol concurred with some of the recommendations made by Craig *et al* (2000).

In addition to this protocol, I as the researcher had a responsibility to assess the safety of the environment I was entering. Issues such as the presence of other people, evidence of disturbance, and the attitude and behaviour of the participant were considered when I entered the participant's home. It was agreed with my supervisors, that if I assessed that there was a risk posed to me then I would make my excuses and leave. I was also mindful of where I positioned myself in relation to the door, and of escape routes should it be necessary to use these. The following entry in my field notes reflects my concerns regarding safety:

*"I had spent a lot of time contemplating the risk posed by Peter; particularly as I knew he had been brandishing a weapon prior to his admission to hospital. This awareness had made me particularly conscious of my dress – I opted for plain T-shirt and jeans and trainers in case I had to run. I also shortened the length of time I gave myself before calling in at the end of the interview. I felt this made me a bit safer. In the event there was no sense of threat, although the pictures and dimly lit room did nothing to calm my initial nerves."*

(Extract from fieldwork journal, 16 June 2006)

Whilst I remained acutely aware of issues of safety when interviewing, my initial meetings with participants whilst they were on the ward had allowed me to make some preliminary risk assessment. Ward staff had also made some assessments of risk based on their knowledge of participants' previous history of aggression and violence. Throughout the interview process I did not experience threat from any of the participants.

## **4.5 The search for meaning: Data analysis**

### *4.5.1 Introduction*

Within the field of narrative analysis, there are many different ways of analysing the data depending on the theoretical perspective of the study (Mishler, 2003; Riessman, 1993; Tilley, 2003; Schiffrin, 1997). However, there are decisions that have to be made by all researchers regarding what constitutes the unit of analysis, and defining narrative (Mishler, 2003). Of particular pertinence when drawing up the itinerary for the analytic journey was my theoretical understanding of language and meaning.

If one takes as a start point that language is not transparent, but is itself representative (Viney & Bousfield, 1991; Mishler, 2003; Bakhtin, 2006; Gee, 2005), then understanding another's communication requires more than a direct translation. It requires us to have shared knowledge of language in use, in order to interpret the meaning of the speaker's utterances. Language in use is not just words, it is the manner in which they are fitted together in order to structure a communication that conveys the speaker's meanings (Coffey & Atkinson, 1994; Olsen, 2006; Viney & Bousfield, 1991; Fraser, 2004; Gee, 2005). Thus, the 'how', or structure, of the communication becomes important to understanding the 'what' (Gee, 1991). If the structure of a stream of speech holds clues to the meaning it conveys, it follows that the preservation of the structure in which the words are held will be necessary for the interpretation of the speaker's meaning.

It is on structure that Riessman (1993) suggests analysis focus initially. In beginning with structure, the researcher circumvents the natural tendency to focus on narrative content, and thus the danger of interpreting the meaning of the narrative from their own theoretical position. By focusing on how meaning is conveyed through the structure of the narrative, the focus shifts to what the teller is trying to show us, allowing us to get closer to the teller's experience (Riessman, 1993).

My choice of analytic approach was therefore based on the following theoretical principles:

- ❖ The language used within narratives is not transparent, the meanings of words and phrases are 'situated'.

- ❖ How a person tells his or her story is part of how they convey their intended meaning.

In tandem with the methodological choices that had to be made, I experienced a huge sense of responsibility toward the participants, chunks of whose lives were held within the pages of the transcripts. The transcripts contained intimate details of participants' experiences, some of them having told particular stories for the first time during our interviews. I was aware of their hope that telling their stories would make a difference; that they would have an impact on those who encountered them. The following reflection from my research journal illustrates the emotional impact of the shift from data collection to analysis:

*"It is a strange process that takes you so far into somebody's life for such a brief period ...I take possession of part of their life story – their meanings and experiences – to make into something which no longer belongs solely to them but which is fashioned, via analysis and reframing, by me. My relationship is no longer with the participant but with the material of our interviews, stories moulded by both of us...The research process leaves the researcher alone with the job of making sense of the data, always with the knowledge of the audience to whom the research will be addressed; part of that audience is the participant group."*

Thus, despite having ended the physical interaction with the participants, I remained in relationship with them through the data. In so doing, I was continually mindful of the ethical requirements of the relationship. Knowledge that participants will read what you write about them undoubtedly influences that process (Josselson, 1996; Lieblich, 2006). Thus, whilst data analysis may be the responsibility of researcher alone, it is nevertheless carried out in the context of the relationship with the participant.

#### 4.5.2 Defining the unit of analysis

4.5.2a *Holistic or fragmentary analysis?*: Before analysis could proceed, I had to define the unit of analysis (Mishler, 2003). Within the narrative research literature, two seemingly opposed approaches to this issue were uncovered. One approach takes fragments of the narrative, words or phrases, as the unit of analysis. These fragments are then abstracted from their context within the data and subjected to analysis (Strauss & Corbin, 1998; Lieblich et al, 1998). The aim is to work across the data set, generating categories and themes which form the evidence base for theory. This

approach focuses on the ‘what’ of the narrative rather than the ‘how’ of its telling. The treatment of parts of the narrative in abstract form strips them of their context, as aptly described by McCormack (2004: 233):

*“During the recombination of codes into themes, the clues to understanding provided by language features in their transcribed context are lost. The same words may have different meanings in different contexts.”*

Thus, through the process of fragmentation and reconstitution into themes and categories, situated meanings contained within the data are lost. This leaves the researcher, without the clues provided by the original context of the fragments within the participant’s narrative, to interpret the data from within his or her own theoretical concepts. Clarke et al (2005) made the following reflections on their fragmentary analysis of participants’ stories:

*“Our categorical thematic analysis provides a particular picture of the stories of the research participants. In breaking experiences into parts, it neglects the move and sway – the chronology – of the stories as they are actually shared. It values the rational, informative, and the cognitive over the non-rational, experiential and evocative. It tends to reduce experiences to the categories of analysis predetermined by the researcher.”*

Clarke et al, 2005: 928

The dissatisfaction experienced by Clarke et al (2005) appears to be linked to the loss of the individual within the fragmented data. However, they also acknowledge the contribution that fragmented analysis might offer.

The theoretical principles set out at the beginning of this section place language in use as central to our understanding of the narrator’s meaning. A holistic approach takes the narrative as the unit of analysis, thus retaining its integrity and making accessible the situated meanings contained within (Lieblich et al, 1998; Lieblich, 2006). This approach to analysis is congruent with the theoretical concepts discussed in Chapter Three: that meaning is contextually dependant, and the structure of narrative contributes to its meaning. I therefore chose to adopt this approach to analysis because it allowed me to focus on the ‘how’ as well as the ‘what’ of the narratives.



#### *4.5.2b Narrative as the unit of analysis*

The data contained many small narratives with discrete boundaries. However, I also conceptualised the interview itself as a narrative, a big narrative of the individual's experience of being a patient. For the purposes of this study, I chose to define the unit of analysis as the small narrative. Treating the interviews as big narratives, inlaid with smaller narratives, allowed me to attend to both the structure and the context when deciphering the meaning of participants' narratives. Each small narrative was both a narrative that could stand alone, offering a particular perspective on an aspect of the participant's experience, but it was also part of a greater whole, as the small narratives weaved together to build the big narrative that was the participant's experience of being a patient in the acute ward.

*4.5.2c Identifying small narratives for analysis:* I conceptualised the interviews as a big narrative, containing many small narratives that interweave. It was these small narratives that formed the unit of analysis, and therefore had to be identified within the interview transcript for analysis to progress. Guided by Gee's (1991) theories, I set out to identify these small narratives.

Unlike Labov's (2006) approach, where narrative is identified by application of strict criteria regarding temporality and content, Gee (1991) conceptualises narrative as passages of speech that fall into patterns of lines and stanzas. He does not contend that there will be a particular pattern to the content, but instead focuses on how narratives are spoken. For Gee (1991), the narrative begins with a dysfluency, a pause, false start, or shift in topic. This dysfluency, he contends, is caused by the narrator focussing inwardly, as he or she organises the narrative they are about to embark on. To identify narratives using Gee's approach, it was necessary to transcribe all para-linguistic material. Thus, the method of transcription became central to my ability to identify small narratives within the wider text.

#### *4.5.3 Transcribing interviews*

##### *4.5.3a Transcription as interpretation*

*"Transcripts are our constructions and making them is one of our central research practices."*

Mishler, 2003: 317

There is a body of literature that recognises the importance of transcription work as part of the interpretive process in qualitative research (Riessman, 1993; Mishler, 2003; Tilley, 2003; Coates & Thornborrow, 1999; Fraser, 2004; Libliech, 2006). During transcription, I made decisions about where speakers' turns ended, and how to represent them on paper, for instance, by making choices about whether to put a pause between speakers at the end of the first speaker, beginning of the second or between them (Mishler, 2003; Tilley, 2003). The transcripts were, therefore, not direct translations of a speech event, but representations, subject to my interpretation of what I had heard.

How we choose to represent what we hear in the form of a transcript should be theoretically driven (Riessman, 1993; Mishler, 2003; Tilley, 2003; Gee, 2005; Kendall & Murray, 2005), bringing to the fore certain features and leading to particular analyses (Riessman, 1993; Coates & Thornborrow, 1999; Kendall & Murray, 2005). Transcription is thus, where analysis starts, and the choices we make during the transcription process set us on particular analytic paths (Tilley, 2003; Riessman, 1993).

In order to facilitate the analysis of narratives based on Gee's theories, it was necessary to transcribe all para-linguistic material so that both structure and content of the narratives became visible. Pauses, disfluencies, false starts, non-lexical utterances such as uhu, mmhm, and so on were included to facilitate the identification of narratives within the interview. Coates and Thornborrow (1999) recommend checking transcripts alongside the audio files to ensure best fit, thus acknowledging the interpretive nature of transcription. As I carried out this process of checking I heard features that I had not heard previously, or would re-consider the punctuation of a speaker's sentence: the work of transcription seemingly never done.

The initial transcripts of the first interviews were read to draw out the main themes of the participants' narratives. These were summarised and sent to the participants at least seven days prior to the second interview (see appendix 5 for example of summary transcript). The participant's views on my initial reading of their interview,

corrections of misunderstandings and elaboration on particular areas, formed the basis of the second interviews.

*4.5.3b Re-transcribing narratives using Gee's theories:* Narrative passages were identified within the interview transcripts by dysfluencies in the narrator's speech. I then proceeded to re-transcribe these narratives using Gee's (1991, 1986, 1985, 2005) theory of language. Gee's (1991, 1985, 1986, 2005) theories contend that speech has a poetic form, and that narrative is therefore organised into poetic structures: lines and stanzas. These poetic structures are identifiable by attending to the tone and emphases of the narrator's speech. Lines are made up of one tone unit, which displays a constant level pitch. A pitch-glide, change of pitch, followed by a brief pause, generally marks the end of a line in English spoken language. The pitch-glide also demarcates the material in the line that the narrator wishes the listener to take as new or asserted information (Gee, 1991, 1986).

Related lines form stanzas, focussing on one perspective, event, theme or topic, like a single camera shot (Gee, 2005, 1991, 1986). The lines are patterned, and stanzas throughout a narrative are generally balanced in terms of length. A new stanza is indicated by a shift in focus, as well as often by a slightly longer pause than is evident at the end of a line. Related stanzas can be organised into strophes, which can then be organised into parts.

Gee (1991) uses particular notations in order to make the narrative structures visible. The narratives were re-transcribed into lines and stanzas through careful listening for changes of tone, pauses, false starts and other dysfluencies (although many of the latter were already contained in the initial transcripts). The material that was identified by the pitch glide as new or asserted was typed in UPPER CASE in order to make it visible. Brief pauses within a sentence were marked by / between idea units. By re-transcribing the narratives in this form, the structures that Gee contends are meaning-related were made visible for further analysis.

The re-transcription of narratives using this approach was an intensive process, involving detailed listening so that I could pick up on pitch glides indicating the end of the speaker's phrase, emphasis on particular words, and identify how the text fell

into lines and stanzas. This process of parsing narratives into poetic form brought to my attention many features I had passed over when treating the text in its previous format. As these re-transcriptions progressed, the intensity of listening, and the minute attention to intonation, pauses, and use of cohesive structures led me to become immersed in the participants' narratives.

*"I felt Gee helped me notice so much more, and now even when I read the text of interviews not re-transcribed I examine more closely the speaker's use of language and their means of connecting phrases."*

Extract from fieldwork journal, 28 August 2007

The final products of this re-transcription process were narratives that were displayed using a poetic structure. Each narrative had been divided into lines, stanzas strophes and parts. The line usually consisted of a single idea unit, or tone unit, the basic unit of narrative. Lines focussed around a particular perspective on the same event became the stanzas. These were generally short, 4-6 lines in length, and conformed to a particular pattern within a narrative. Related stanzas were grouped into larger structures, strophes. It was then possible to assemble related strophes as parts, the largest sub-unit of the narrative (see appendix 6 for example of re-transcription into this form).

The intensity of this form of re-transcription was tremendous. The transcripts for each interview were between thirty and sixty pages in length, and contained large numbers of narrative passages. The amount of time that was necessary to carry out the re-transcription of all narratives led to the decision that it was impractical to undertake this work with all thirteen participants. It was decided, in conjunction with my supervisors, that I proceed with Gee's re-transcription procedure using six participants' interviews (12 transcripts in total). The other interviews were transcribed and narratives identified and analysed holistically, but only particular narratives pertaining to the themes that developed from the analysis were re-transcribed using Gee's (1991) theories. However, it is worth noting that, because of the long hours I had spent immersed in this work using Gee I was able to hear the other transcripts in light of this, and thus, the analysis of these interviews was also heavily influenced by Gee.

#### 4.5.4 *Anonymity and the assignment of pseudonyms*

The principle of anonymity was defined in section 4.2.4. Anonymity refers to attempts to hide identity within the products of research (Grinyer, 2002), reducing the likelihood of recognition by others. Anonymity is generally sought through the use of pseudonyms, and the deletion of other identifying details. During the interviews for this study permission was sought to use quotes from the interview transcripts within any published material. All participants gave such permission yet this did not preclude me from the responsibility of making the decision about what should remain in the private domain.

The assignment of pseudonyms to participants was a further attempt to offer anonymity. For this study, the use of pseudonyms was a condition of ethical approval, thus assuming that they are unquestioningly beneficial to participants. Grinyer's (2002) reflections on the use of pseudonyms in her study of families with an adolescent cancer sufferer throw this assumption into question. She found that a large proportion of her sample wanted to have their real names used in the text of her report. Participants who requested this had felt that when they saw their story attributed to a pseudonym they could not recognise it as theirs. Within the study, because of the constraints of ethical approval, there was no opportunity for participants to go by their own name in the text. However, so that participants might have their story attached to a name that they could relate to – some names have bad associations for people, or just do not seem to fit the person (Grinyer, 2002) – they were given the opportunity to choose their own pseudonym. None of the participants opted to choose their own pseudonym, thus the assigned names reflect my values and associations in my attempts to assign names that seemed “*equivalent*” (Grinyer, 2002: 2).

My anxiety about the assignment of Amanda's pseudonym is clear at the beginning of the second interview. Although indicating that this is not a name that she would associate with, it is my associations with it, and therefore my evaluation of her as a person, that are of interest to her:

*“Me: Did you see I called you Amanda? Is that alright? You're pseudonym is Amanda. Wondered if you would em...”*

*Amanda: Yeah, I've been called worse.*

*Me: It's quite hard picking pseudonyms really. It feels like quite a responsibility.*

*Amanda: Do you relate to Amanda?*

*Me: Em, well, I have a friend Amanda actually who...yeah...it's a name that I associate with people that I, that I know and like, yes.*

Pseudonyms were attached to each audio file and transcript, thus keeping all identifying material separate from the content of each interview.

#### *4.5.5 Analysing the data*

During the re-transcription process, the focus words were identified by listening for changes in pitch, and were made visible within the transcript by using capital letters. The focus words for each stanza were then extracted and arranged together so that all of the focus material for a particular strophe could be viewed together (see appendix 7). The images conjured up by the focus material were then noted and the evidence for these images described. Notes of these images provided a background against which I attempted to answer the interpretive questions generated when examining the data.

I analysed each narrative line-by-line, focussing on how the narrator had used cohesive devices and grammar. My interpretations were written up for each stanza, and then for each part, and narrative as a whole (see appendix 8). Thus, the detailed examination of the lines occurred in the context of their function as part of an entire narrative.

Having interpreted the narratives in light of their structure, I focussed on how the individual narratives cohered to make up the big narrative that represented the interview as a whole. I observed that, for each participant, there were a number of themes that wove their way through each participant's interview like threads binding disparate parts to make a cohesive whole. These themes bound the discrete narratives about particular aspects of the participant's experience together to form the big narrative, the story of the person's experience of being a patient on the acute ward.

## 4.6 Presenting the data

### 4.6.1 Introduction

How I chose to present the data implicated my interpretation of them, as well as mediating their impact. Lieblich (2006) refers to what she terms the ‘*performance turn*’ (61), the consequence of a rise in post-modernist epistemologies, and the ensuing contestation of issues pertaining to “*writing and representation in our academic field*” (Lieblich, 2006: 61). This shift has legitimated the adoption of a diverse range of presentational media by researchers, including the use of plays (Ellis & Bochner, 1992; Lieblich, 2006); poetry (Hill, 2005; Kendall & Murray, 2005; Richardson, 1992; Clarke *et al*, 2005; Kidd & Tusaie, 2004; Chapman, 2007; Holmes & Gregory, 1998); and short stories (Parry, 2004, 2006; Shingler, 2007; Shelton & Johnston, 2006). These modes of presentation value aesthetic ways of knowing, presenting perception rather than scientific ‘facts’ (Hunter, 2002; Kidd & Tusaie, 2004; Holmes & Gregory, 1998). Such ways of knowing occur through the interaction of the consumer with the text; their empathic response to the other’s experience (Kidd & Tusaie, 2004; Kendall & Murray, 2005). Hunter (2002) states that knowledge gained through aesthetic means is ideally suited to nursing where relationships are central. The sensitisation to others’ experiences that is possible through the nurse’s empathic response to the research can be used to increase the nurse’s skill when dealing with patients.

### 4.6.2 Poetic re-presentations

*“Creating poetic portraits allowed me to convey the spirit of their beings in a way that other, more traditional, forms of data documentation would not enable”*

Hill, 2005: 104

*“Given recent work on the vital role of emotion in moral knowledge, which emphasizes (sic) how often we know what we think about a particular topic by reference to how we feel about it, it is crucial that patient accounts arouse an emotional response.”*

Kendall & Murray, 2005: 746

The study aimed to shed light on participants’ experiences, it was therefore incumbent upon me, as author, to present the data in a manner that promoted the possibility that

readers would gain a sense of participants' experiences. Evocative and vivid, poems breathe life into the everyday, providing us with a new perspective on the familiar (Hill, 2005; Holmes & Gregory, 1998; Hunter, 2002; Shklovsky, 1965). They present the 'essence' of an experience, showing rather than telling, igniting the imagination of the reader who recognises his/her own experience in the lines (Clarke *et al.*, 2005; Holmes & Gregory, 1998). We read every word of a poem, saying it rhythmically in our heads, yet we often skim blocks of prose, noting only what seems important (Kendall & Murray, 2005). It is these qualities of poems, engaging readers, connecting with them emotionally, that led me to use them as a medium for presenting the participants' experiences.

#### *4.6.2a Development of the poetic re-presentations*

Previous authors who have developed their research findings in the form of poetry have constructed the poems in different ways. Richardson (1992) writes of how she developed a poem to represent the life of one of her interviewees. She used only the interviewee's words and drew upon poetic devices such as "*repetition, off-rhyme, meter, and pauses to convey her narrative*" (Richardson, 1992: 126). Hill (2005) created what she refers to as "*poetic portraits*" (95) to represent the narratives of her interviewees. In contrast to Richardson (1992), Hill developed her poetic portraits from the themes that arose from her analysis. These themes provided the core of the poems, and she used direct quotes to "*confirm the themes and give honor (sic) to their voices*" (Hill, 2005: 96). Adopting yet another approach, Kendall and Murray (2005) developed poetic presentations of the data from their narrative study. These poems were developed using Gee's (1991) theories, and represent a re-transcription of the identified narratives into poetic form. They are therefore developed entirely from the participants' own words.

The poems in this study, similarly to Hill's (2005), were developed from my analyses of the content of the narratives in an attempt to allow the reader to gain a holistic view of the participants' experiences. Each poem embodies my understanding of what the participant was trying to convey about their experience.

The poems were developed to reflect both the *how* of the narratives as well as the *what*. I have tried to remain true to the form of speech, and language, used by the



participant, and have included, verbatim, phrases and images that were central features of the narratives. The form of the poem, its presentation on the page, the length and rhythm of the stanzas, the inclusion of a refrain, reflects how participants told their stories, and how they positioned themselves within these. For instance, John's narrative felt staged, like a music hall production. When analysing John's transcript I noticed that I connected with memories of Jack Mulroy's<sup>10</sup> performances. Whilst writing his poem one of the later stanzas had a rhyming structure. This rhyming stanza felt different when read, it kept the reader at a distance, just as I felt John's highly rehearsed stories had done. I decided to rewrite John's story in rhyme as I felt that it represented how he had told his story. Similarly, Cathy's narratives were full of contradictory statements where on one hand she offered criticism and then immediately after, she praised the ward. When creating Cathy's poem I juxtaposed each side of her story using both sides of the page to convey this sense of dissonance.

The poems, presented in Chapter Eight, bring together the material that was explored in detail in the previous three chapters, bound together to form a holistic presentation of each participant's experience. In doing so, the poems exemplify the different viewpoints that participants adopted when narrating their experience. For some of the participants their narratives were focussed on issues of power, whilst others focussed on help and safety. Whilst each poem includes elements of all of these themes, they reflect the focus and balance of the participants' narratives. The distillation of the participants' experiences into poetic form allowed me to present their experiences in a holistic manner, retaining their personal qualities.

#### *4.6.3 Thematic presentation*

Alongside the desire to retain the individual nature of the participants' experiences, and having found a means to do this through the poems, I felt that I needed to present the data in a way that exemplified the commonality of experience that I perceived was evident in the analyses. Aware that this would require me to fragment the data, I decided to work with the holistic analyses, and use the meanings that I had developed

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<sup>10</sup> Jack Mulroy was a well-known Scottish comedian whose music hall persona as half of the duo *Francie and Josie* was a part of my experience of growing up.

within these from which to attempt to develop themes. Different ways of fitting the data together presented themselves, and each offered a different view of the participants' experiences. For instance, the analyses could be fragmented on the basis of relationships, and viewed as narratives pertaining to participants' relationships to other patients, and to the nurses. Fragmentation along these lines did not seem satisfactory. However, it gave me a start point, and as I continued to work with the data I developed an awareness of three discourses that participants were drawing upon whilst attempting to make sense of their experience.

In order to make sense of their experience participants must use a discourse model (see section 3.3.3), that is, a conceptual framework that enables a particular discourse to be applied to a local situation. Through this process the participants drew on particular discourses in order to interpret events. The interpreted events were narrated as experience (see section 3.3.1), thus the participants' narratives were intrinsically linked to discourse.

Within their narratives, participants drew on three discourses of help, safety and power. However, they did not draw equally on these discourses when interpreting their experiences. Examining the holistic analyses, it became apparent that participants had drawn heavily on either ideas pertaining to help or those pertaining to power when interpreting their experiences. The concept of safety appeared to bridge both help and power in that it was perceived as part of being helped, yet narratives of safety also drew on discourses relating to power.

Thus, the participants drew on common discourses when narrating their experiences. Each thematic chapter presents the data that relates to one of the three discourses. By presenting the data in this way, I aimed to convey the sense of common experience that was identified through the holistic analysis of each participant's narratives. It is through the illumination of such commonality that the experiences of individuals gain a collective power, uniting in a common voice.

#### *4.6.4 Limitations in representing the constructed nature of the data*

Within the theoretical framework of this study the data are conceptualised as jointly constructed between participant and researcher in the interview context. Thus, as the

researcher I am inextricably bound up in the data. My influence on the data is not only exerted through the words I uttered, but through my body language, and simply through my presence. It is therefore impossible to disentangle the impact of my presence and interactions as researcher from the narratives that were created.

Presentation of lengthy parts of the transcript, an approach adopted by Riessman (1989) in her paper showing how the participants in her study of divorce developed their narratives, would allow the reader to assess, to some extent, the impact of my presence on the data. However, within the context of this thesis, this approach to presentation of narrative excerpts would have been too cumbersome. Within the interview transcripts it was clear that participants would often begin a narrative that they then let go, only to pick it back up at a later point in the interview. In these cases it would be almost impossible to present the narrative as it developed without presenting the entire interview transcript. Within chapters Five to Eight I have therefore presented the narrative excerpts without presenting all of the interaction between myself and the participants. This limits the transparency of my interpretations, as it does not give the reader access to all of the material upon which my interpretation of meaning is based. However, bearing in mind the intangible aspects of my influence - through the participants' interpretation of my subjectivity - it becomes impossible to make my impact on narrative production, as researcher, fully visible and thus the presentation of data to support my interpretations becomes my authorial responsibility.

#### **4.7 Introduction to the data chapters**

In the four chapters that follow I present the data from the study. In Chapter Five I examine the participants' narratives as they relate to issues of help. Participants expressed the expectation that they would receive help whilst on the acute ward, and indeed that they had agreed to admission on the grounds that they would get help. Help was envisaged as taking a number of different forms, however, talking to the nurses was the main form of help that all participants expected. Participants expressed a number of barriers to getting this form of help, not least those created by a ward policy whereby the nurses expected participants to initiate interaction if they

needed to talk. Participants' narratives made explicit the frustration and disappointment that they experienced when this form of help was not forthcoming, and the strategies they developed in order to cope with this situation whilst resident on the acute ward.

Chapter Six focuses on participants' expectations and experience pertaining to being safe on the acute ward. As in relation to getting help, participants made their expectations pertaining to being safe explicit within their narratives. However, whilst participants felt protected from the stresses of the world outside the ward, they nonetheless felt threatened by the ward environment, and in particular, some of the other patients on the ward. This sense of threat was derived from participants' lack of knowledge about their fellow patients, thus requiring them to draw on a discourse that associated mental illness with violence and unpredictability. Participants expected the nurses to keep them safe from the other patients, however, when the strategies adopted by the nurses to deal with aggressive incidents did not coincide with participants' concepts of the action that should have been taken, participants experienced a sense of vulnerability. Feeling safe was also linked to the gender of the staff team, with males perceived by participants as more able to keep them safe. Participants also developed their own strategies to keep themselves safe whilst on the ward.

Chapter Seven sets out the data pertaining to the theme of power. Power was closely linked to the themes of help and safety through the attribution of power to the nursing staff who were expected to keep the patients safe, and to help them. Participants' narratives illuminated their conceptions of the power hierarchies operating within the ward. They perceived the psychiatrist as occupying the apex of this hierarchy, and the ward staff as working for the psychiatrist. The nurses were perceived as carrying out observations upon which they based their reports to the psychiatrist. It was through this role in surveillance that the nurses were attributed power by the participants. Participants responded to the knowledge that they were being observed by adopting a number of strategies to control their self-presentation with the aim of controlling what was reported.

Chapter Eight presents the poetic re-presentations of my analyses of the participants' narratives. Developed from the holistic analyses of participants' interviews, these poems represent my interpretation of each individual's experience. Whilst representing individual perspectives on the experience, these poems also make visible the elements of common experience that inform the three previous chapters.

## **5 Help: Expectations and Experiences**

### **5.1 Introduction**

Issues pertaining to the help that participants expected to receive on the acute ward, and what they experienced, form a strong theme running across the data set. Whilst the narratives of all of the participants encompass issues relating to getting help, for Jill, Joanne, Josie, Ewan and Connor this was the main theme that bound their narratives together.

In this chapter I present data relating to the participants' expectations regarding the help they would receive whilst on the ward, and the role that these expectations played in their admission to the ward. Participants' expectations related to the concept that the ward staff would do something to or for them that they would find helpful. In their narratives they indicated the form that they expected help to take. Some participants narrated expectations of particular activities both to occupy them and with a therapeutic orientation. However, all participants expressed the idea that they would be able to talk to the nurses about their problems.

Participants' expectations regarding the help that would be available on the ward influenced their willingness to be admitted. Most participants were admitted to the acute ward on a voluntary basis. Their narratives indicate that the decision to allow themselves to be admitted involved balancing a number of factors against each other. These factors included their expectations and beliefs that the acute ward would offer them the necessary help, hopes that the help gained from admission would outweigh the negative impact of admission on their social relationships, as well as taking into account the opinions of others about what was best for them. Through their narratives, participants conveyed the extent to which their expectations were congruent with their experience.

The expectation that they would get time to talk about their problems with the nurses led to feelings of frustration and abandonment as participants found the nurses difficult to access. Participants' narratives about talking with the nurses illuminate

the difficulties they encountered when trying to access this form of help. It is these issues that I examine in the second part of this chapter.

In the final part of the chapter I examine participants' response to their perception that the help they needed was not forthcoming from the nurses. Participants' narratives indicate that they developed relationships with other patients through which mutual support was gained. Whilst this provided a partial solution to their needs, it was not without its problems. Some participants felt burdened with the problems of others, and the closeness of the relationships formed left them vulnerable to getting hurt when the other party was no longer on the ward.

## **5.2 Expectations of help as a main influence on decisions to accept admission to the ward**

### *5.2.1 Introduction*

All but two of the participants had been admitted onto the ward as voluntary patients. Often participants were admitted after spending a considerable amount of time at home knowing that their mental health was suffering. Through their narratives, participants made explicit the expectation that they would receive help on the acute ward, and the role that this expectation played in them agreeing to be admitted. Expectations pertaining to what the acute ward would offer seemed to be rooted in ideas transmitted from external sources such as the participant's GP or family, or in the participant's own perceptions or experience of hospital.

### *5.2.2 Expectations of help originating from external sources*

Both Jill and James experienced their interactions with their GPs as promoting admission to the acute ward as a place where they would receive the help they needed. During one of his narratives, James recalled how his GP had suggested he become a voluntary patient on the acute ward. By making the link between James being ill and admission to the acute ward, James is alluding to his sense that the GP expected admission to make him better:

*“It was my social worker who said,  
'look, we need to go to the doctor's now',  
because of the way I was talking to her.  
And then we went to the doctor,  
and he said, 'you're ill.*

*I want you to voluntarily go up to [name of local psychiatric hospital].’”*

James, interview 1

Jill’s GP had suggested that she attend the acute ward for assessment of her mental health. Both the GP and her parents encouraged her to accept the offer of voluntary admission, and she agreed to stay out of a sense of loyalty to them. In her second interview she talked about her parents’ expectations that she would be helped:

*“And I mean, my parents were so upset.*

*I mean my mum was in tears*

*and she felt really, really guilty,*

*that they had encouraged me to go,*

*because like me, they had thought I would go in and get the sort of help and attention,*

*and could see the visiting time they came in that there I was,*

*still behind closed screens,*

*lying on the bed*

*and it really, really upset them as well.*

*In fact my mum had said,*

*‘you know, if it’s no better on Monday,*

*we’ll take you home.’”*

Jill, interview 2

The expectation that she would receive help on the ward, and Jill’s perception that this was not forthcoming left her feeling that she had been “conned”, a theme to which she returned regularly during her narratives:

*“But I felt really conned,*

*that I had come in thinking there would be people there to help me and,*

*initially, there was none,*

*there wasn’t.”*

Jill, interview 1

### *5.2.3 Personal beliefs that admission to the acute ward will help*

Some participants’ narratives made it explicit that they themselves held beliefs that the acute ward would help them to get better. Holding such beliefs actively motivated participants who realised they were ill, to seek admission to the acute ward. These beliefs often stemmed from previous experience of being on the acute ward. However, although he had never been admitted to the acute ward, Peter felt sure that this was the best place for him to get help. This led him to take purposive action so that he would gain admission.



On realising he was unwell, Peter had asked his GP several times to get him admitted to the acute ward, but she had told him that he was not ill enough:

*“I had been to the doctor four times in the last month and said to the doctor,  
‘ I know I’m ill,  
I know I’m getting ill,  
can I not just sign myself into the [name of acute ward].’*

*I just wanted to get somewhere I could get treated  
and my symptoms were a lot more acute, and a lot more rapid.  
The doctor said, ‘you have to go for assessments first,  
you’ve got to adhere to the rules.’”*

Peter, interview 1

Aware of his deteriorating mental health, and unable to gain admission through his GP, Peter described how he planned to get admitted via the criminal justice system. He then deliberately set out to get himself arrested by the police, convinced that they would see how ill he was and transfer him to the acute ward:

*“So I thought  
if you hit a car door  
and the alarm will go off  
and somebody will phone the police.*

*The police will calm me down  
and they’ll take me to hospital.  
That was my intention.”*

Peter, interview 1

Like Peter, Josie had to push to get admission to the acute ward. Despite perceiving admission to the acute ward as stigmatising, Josie felt that it was the only option that would help her get better. Her reference to admission as “*something drastic*” conveys the sense that admission to hospital was not considered lightly:

*“I went to see the psychiatrist  
and eh, I was at the stage by that time  
I knew I had to go to hospital  
I knew that something drastic was needing done,  
  
and I had a row with the psychiatrist,  
I lost the head  
and eh, he says ‘we’ll see you in another three weeks.’  
I says, ‘I’m here asking you for help  
and you’re just going to see me in three weeks’  
he was just going to palm me off in all.”*

Josie, interview 1

Having been recently discharged from the acute ward, Connor was aware of the help available to him on the ward:

*“The second time I went up to the [name of psychiatric hospital] the minute I get through the door I felt braw. I felt like there was a weight off my shoulders. I’m in here to get help outside there’s no help.”*

Connor, interview 1

Thus, Connor’s previous experience of the ward as helpful created the belief that it was where he needed to be. Believing strongly that the acute ward was the place that could help him, Connor worried that they would not re-admit him:

*“I was terrified that they weren’y gonnae let me in and I knew I needed help I thought they’d turn round and say, ‘you’ve already been here. Not much chance for you.’”*

Connor, interview 1

Ewan was referred to the acute ward by his GP. However, Ewan’s previous experience of admission to the acute ward led him to believe that it was the best place for him to be:

*“I actually went to the [name of practice] doctor because I’m still registered there. And she says, ‘well, we’ll try and get you in [name of acute ward].’ I’ve only been in there once before and eh I thought, ok, I’ll go in there then, they do, I mean they work miracles, ken well twice for me they have, and what they did when I went in first they said there was a chance that I had an overactive thyroid or an underactive so I was getting checked for that as well.”*

Ewan, interview 1

#### 5.2.4 Balancing expectations of help against the negative social impact of admission

The decision to be admitted onto the acute ward involved the balancing of participants’ knowledge of the stigmatising effect of admission with their need for, and expectation of, help. Participants therefore expected that the help available on the

acute ward would outweigh the negative social impact of admission to the ward. Jill perceived the fact that she had been admitted to the acute ward as stigmatising, and experienced anger at the thought that she had to endure the stigma without perceiving any benefit to her health:

*“I still feel there’s a bit of a stigma attached to it.  
But, it’s in my notes now  
that I’ve been in an acute psychiatric ward.  
And I think I could deal with that better if I felt they had really helped me,  
and I’d gone in there  
and they’d been able to do something for me.”*

Jill, interview 1

Whilst not verbalising the anger experienced by Jill, Josie’s narrative was infused with disappointment. She had pushed for admission on the assumption that it would help despite her knowledge that it was stigmatising:

*“Well, to me, it’s no so much being the patient  
I’m still a bit old fashioned like that  
it’s the stigma that’s still connected  
when you say you’ve been in [name of psychiatric hospital].*

*The reaction of people when they know you’ve been in a mental institution  
I think the research should contain something like that  
it’s on the television  
I’m a person, you know.*

*I was a bit upset because that time I was in the hospital, eh,  
I had only agreed to the ECT<sup>11</sup> as a last resort  
because they had tried me on so many different medications  
and I was just at the end [of my tether]*

*and eh, it didnae work,  
it didnae work,  
and I actually just came out the hospital  
the same way I went in.”*

Josie, interview 1

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<sup>11</sup> Electroconvulsive Therapy

Admission to the acute ward had placed James' family relationships at risk:

*"There was risk in it [hospital admission] as well,  
with my family situation,  
because we ended up talking about splitting up over it."*

James, interview 1

All of these participants embraced the expectation that admission to the acute ward would help them feel better, and for each there was an expectation that something would take place on the acute ward that would make this happen. Admission occurred at a point when participants were aware of their need for help, and thus the power of others' expectations that the ward would provide the necessary help may be particularly potent. Those whose narratives indicated that they had instigated the admission process implied the need to fight to get admitted onto the ward. This determination to get onto the ward highlights the expectation that being on the ward would help them.

### **5.3 Focussing on nurses as the main source of help on the ward**

#### *5.3.1 Introduction*

With a continuous presence on the ward, nurses constitute the greatest proportion of the ward team. They are therefore the members of the ward team with whom the patients have most contact. Through their narratives, participants made explicit their view of the nurses as embodying the ward's capacity to help them. They expected the nurses to be available and accessible to them. In their narratives, participants made links between whether the nurses cared and the nurses' active initiation of contact with patients. In this section I focus on the issues arising through participants' desire to talk with the nurses.

#### *5.3.2 Expecting nurse-initiated interaction as indication of caring attitude*

The participants convey an expectation that the nurses would initiate interactions aimed at helping them deal with the problems for which they had been admitted to the ward. It is the process of initiating these interactions that the participants linked to a feeling that the nurses cared about them; by initiating interaction with patients, the

nurses were perceived to care about them. This is exemplified in the following comment from Connor's narratives:

*"On each shift there is a nurse allocated to you  
and comes along and says,  
'how are you getting on?'"*

Me: so there is a sense that they are looking out for you?

*Yes, I've seen some people have a bad day,  
really down and they're crying and that,  
and the nurses will notice it."*

Connor, interview 1

In his narrative Robert also made explicit the link that he perceived between the nurses approaching him and the feeling that they care:

*"When I was in [name of other psychiatric hospital]  
the nurses there used to come and approach you if you weren't very  
forthcoming  
and took an interest in you,  
and you felt a bit more cared for in that respect."*

Robert, interview 1

Jill conveyed her feeling that the nurses did not care for her through her narratives where she described their lack of attention to her obvious need:

*"I was sat behind my screens again all of Sunday.  
So, with just people coming and shouting, "it's meal time,"  
going up,  
eating my meal as quick as I could,  
and coming back.*

*It was obviously quite apparent I was upset and crying,  
and nobody came to me."*

Jill, interview 1

### 5.3.3 "You have to come and find us": Accessing the nurses for support

Within the acute ward patients were expected to approach the nurses should they wish to talk. However, some participants were unaware of this expectation until they had been on the ward for some time. Lack of awareness of this system led Jill to feel neglected by the nurses when her expectation that they would attend to her needs was

not fulfilled. Having spent three days on the ward waiting for the nurses to approach her, Jill was informed that she should approach them:

*“I was told then, “look, you have to come,  
if you need to speak to us you have to come and find us.”  
That had never been explained to me either.*

*Even if it had,  
when you’re feeling so desperate,  
so awful,  
I don’t know that I would have.”*

Jill interview 1

In the above quotation, Jill indicates that there are barriers created by her illness that might prevent her approaching staff. Later in the interview she returned to the issue:

*“... and if I need to talk,  
I have to approach the staff.  
Again, very difficult when you’ve been ignored for two days,  
weren’t introduced to anybody.”*

Jill interview 1

Joanne referred to *finding out* that this was how the system worked, implying that she was not informed on admission that if she needed to talk to the nurses she must approach them. Like Jill, she too expressed difficulties with initiating interaction with the nurses:

*“I found out if you had any problems you were to go and talk to the staff  
but I found it hard to talk about things”*

Joanne, interview 1

As indicated by Jill and Joanne above, even when participants did know that they were expected to initiate interaction with the nurses they experienced particular barriers to being able to do so. Participants highlighted personality, symptoms, and the perception that the nurses were too busy, as barriers to approaching the nurses.

#### 5.3.4 Personality and illness as a barrier to initiating interaction

In their narratives, both Jill and Amanda indicated that they found it difficult to approach the nurses and ask to talk because it was not in their nature to ask for help:

*“...when I did need help,  
it wouldn’t be in my nature  
I’m not, I’m a, I’m a very independent person.  
I tend to battle on myself.*

*But, I don't know, had I known at the beginning,  
"if you're really distressed come and see us,  
come and talk to us, we'll give you something"  
I don't know if I would have or no[t], I really don't.*

*But I didn't know that was the way the system, obviously, worked."*

Jill interview 1

*"Again, it's expected of you,  
to approach your named nurse,  
which again I don't, (sigh),  
I didn't find particularly helpful.*

*Because, I would be,  
the type of person I am, is,  
I don't want to be a bother,  
and that's part of my illness.*

*"I'll cope, I'll cope."  
I put on my face."*

Amanda, interview 1

Physical difficulties with communication led Joanne to try to make contact with the nurses by writing notes to them, a strategy to which she did not get the desired response. She does, however, consider that had the staff approached her she would have been willing to talk with them:

*"I prefer to write letters  
I found that doing that I didn't get any feedback  
I felt like that was a waste of time.*

*I would have said if staff came up to me and said,  
"do you need to talk about anything?" instead of you having to go to them.  
I just needed a bit of encouragement..."*

Joanne, interview 1

### 5.3.5 Nurses were too busy

5.3.5a "They all said you could come and speak to us...": Participants recalled being told by the nurses that they should come and find them whenever they wished to talk. However, this statement of accessibility was incongruent with participants' experiences that the nurses were always too busy to talk:

*“They all said you could come and speak to us,  
but when you went to go and speak to them, they didn’t have the time.  
They were doing something else.  
They were busy.”*

James, interview 1

In her narratives, Josie too referred to the disjuncture between the nurses’ promise of availability, and the reality of her experience. She deals with this disjuncture by theorising that it is due to a lack of staff:

*“...if you dinnae bother them they dinnae bother you.  
I think it’s like most hospitals, a shortage of staff.*

*And they said ‘remember, any time you’re upset speak to so and so,’  
but I felt that time I was in there, eh,  
I didnae talk to anybody...”*

Josie, interview 1

Ewan referred to the nurses being available to talk about “90 per cent” of the time. In the following excerpt he makes explicit his annoyance that the nurses were not actively seeking to fulfil the expectation that they created when they told patients they could come and speak:

*“...you would maybe get the odd staff saying I’m kinda too busy and that,  
and you’re saying wait a minute, ken,  
I was told if I want somebody to speak to I’d get somebody to speak to.*

*I mean we’re not talking about when there’s an admission coming in,  
or when somebody’s kicking off.  
I’m talking about when there’s no’ much doing and you’d just like to talk to  
them, ken,  
just to try and explain what’s happened.”*

Ewan, interview 1

5.3.5b *“I can’t bother them just now”*: Participants made judgements about whether or not the nurses were too busy to approach. They experienced a pressure not to disturb the nurses if they were busy. This led to them not approaching the nurses:

*“Cos you see them [the nurses] going about doing things.  
You dinnae want to go up to them and say, “can I speak to you?”*

*Sometimes I thought, ken,  
they’re too busy to speak to you  
so actually, I prefer them to come to me rather than having to go to them.”*

Joanne, interview 1



*“I’m very quick on the uptake of the levels of stress,  
probably more so being older,  
having been in management  
you get an idea, “I don’t certainly can’t bother them at the moment.”*

*And then I’ll wait to tomorrow.  
Tomorrow comes, maybe a similar situation,  
or that person you want to speak to is off,  
because you don’t know when they’re next on duty.”*

Amanda, interview 1

5.3.5c *“They were doing something else”*: The administrative duties that the nurses undertook were perceived to make them inaccessible to the participants. Whenever Cathy went to find a nurse to talk to, she observed that they were constantly in the office, writing. She had made several references previously to the amount of paperwork that the nurses had, and her narrative was in response to my question about whether despite having paperwork, she felt that the nurses were available to her. Although stating that she did not feel that the nurses were *“work shy”* her narrative leaves us with a sense of her ambivalence toward them:

*“Yes they were  
but when you went to speak to them they were always writing up files  
you know, I don’t think any of them are work shy or that  
other than staying in the office there which obviously they did.*

*And obviously when they’re doing a synopsis of what I’ve said  
and multiply it by 30 or whatever,  
it takes a lot of time.”*

Cathy, interview 1

Robert too commented on paperwork preventing the nurses from interacting with the patients. However, unlike Cathy, he thinks the paperwork is an excuse that the nurses hide behind so that they do not have to talk with the patients:

*“Staff say they don’t have time  
I don’t believe that.*

*If they’ve got too much paperwork up there,  
employ an administrator to do the paperwork,  
free them up to talk to the patients,  
if that’s what they say, they’ve got too much paperwork.  
I don’t think it’s so much the paperwork as their general attitude.”*

Robert, interview 1

In the above narrative excerpt, Robert implies that he did not consider paperwork to be the role of the nurse, their role being to talk to the patients. James also narrated an incident when the nurses were too busy to talk to the patients because they were undertaking tasks that he considered to be the responsibility of other hospital staff:

*“There was a complete change in the mattresses.  
So it was the actual staff  
on the ward  
that were bringing them all in and out.*

*It seemed absolutely crazy,  
to ask people that are supposed to be nursing.  
Yeah, it seemed crazy to me to  
to do that.”*

James, interview 1

As a result of the staff being taken up with this task, James recalled the feeling that the patients were just to “*get on with it*”. From this statement it can be inferred that James felt that the nurses gave priority to the practical task of changing mattresses, rather than the needs of the patients.

5.3.5d “*They’re not very interested...*”: The experience of the nurses as too busy to talk to them left the participants feeling that the nurses were not interested in them. In the following excerpt Robert makes a strong link between feeling that the nurses care for him and their willingness to engage with him when he asks for support:

*“Some of them obviously do care,  
but some of them are a bit intransigent towards you.  
You approach them for a bit of support  
and they’re not very responsive to you,  
some of them.  
Some of them are good,  
but a lot of them aren’t,  
they’re not very interested in you”*

Robert, interview 1

Later in the same narrative he comments that:

*“You have to fight for time with them,  
you have to fight for time with them,  
it’s as if they’re wanting to get away from you.”*

Robert, interview 1

This feeling that the nurses wanted to get away from him when he was interacting with them resonates with Josie's feeling that she was taking up the nurses' time:

*"And eh,  
I'm an awful sensitive person  
and I felt worse after I'd talked to one of them  
because I got the feeling  
that I'd taken up too much of their time  
  
mhm, but as I said,  
if it wasnae for this doctor,  
I don't know what state I'd have been in altogether,  
he was exceptionally nice and eh,  
time was no option"*

Josie, interview 1

*5.3.5e Nurses taking time to care:* In the above excerpt, Josie strongly implies that it is the giving of time by the professionals on the ward that she found helpful. Through their narratives it is clear that what participants wanted was for the nurses to make time to talk to them. Several participants narrated particular incidents where they felt valued because a nurse took the time to talk with them.

Jill recalls how one nurse approached her and sat down at her bed to talk:

*"She brought a chair and she said to me,  
'you know, I've been so worried about you' ...  
  
You know I said, 'thank you so much'.  
Because, just for somebody to acknowledge that they had actually sussed,  
it wasn't me being you know;  
sometimes you think, is it me?  
Or, am I just thinking this place is awful? You know  
Or I really feel neglected, but is that just part of the way I'm feeling? However,  
for somebody actually to come to me and say."*

Jill, interview 1

In the above excerpt, Jill's reaction seems to be caused by her experience of the nurse's actions as displaying empathy. She later referred to the untrained nurse as "terrific" because he would come and chat with her. These exchanges were not focussed on issues related to her illness, however, his taking time to spend with her was valued by Jill.

It is his willingness to spend time with them that leads both James and Josie to refer to the charge nurse as good at his job. From James' narrative it is also possible to infer that this is especially valued as the charge nurse is recognised as having a lot of managerial responsibilities:

*"...and, eh, at that time, (blows nose),  
there was one nurse I spoke to  
and it was a man  
and he eh, was in charge of the nurses,  
and I felt he was the only one that really thought and took an interest..."*

Josie, interview 1

*"...even though he was the senior nurse  
he was prepared to take some,  
get some time and take us up [for game of snooker].*

*So there was, you know, in that place,  
the most senior person in that place is, in my opinion,  
damn good at his job."*

James, interview 1

## **5.4 Evaluating their stay on the acute ward**

### **5.4.1 "It was a disappointment...": Participants' expectations of help are not met**

Some participants expressed disappointment, frustration, and anger when being on the ward did not fulfil their expectations of help.

*"I don't think I could ever put myself through that again.  
Although now, having been in, I would know what to expect*

*I really did feel that,  
that I thought I was going in so that they could help me.  
I don't feel anybody was interested,  
or very few were interested."*

Jill, interview 1

*"I didn't seem,  
I wasn't getting much help so,  
and the whole point about going in was to try and get me out of the, the state  
that I was in when I went in,  
and instead I was actually beginning to feel worse.*

*You've already reached a low point  
when you have to voluntary put yourself into a mental institution.  
And I know that's not a very PC way to describe it these days,  
but that's what it is.*

*And for you to actually end up feeling more down  
seems rather perverse.*

*You know, I don't think that was quite the way it's supposed to happen."*

James, interview 1

Later in his first interview, James returns to his feelings of disappointment:

*"...it was a huge disappointment.*

*Because it was a relief when they said, 'we can voluntary put you in', it really was.*

*And I thought, 'oh great, I'm going to get some help, some respite',  
and got none of it."*

James, interview 1

Both Joanne and Jill expressed their frustration that all they were offered to help them was medication, a form of help that they perceived did not require admission to the ward. This was an issue about which Jill was particularly angry, as she felt stigmatised by her status as an in-patient on the acute ward:

*"I have the stigma of actually being in hospital.*

*I have put myself through that,*

*that is now in my case notes.*

*For what?*

*Because I have come in here [acute ward] and nobody has come near me.*

*I could be in a hotel with somebody giving me pills at night.*

*That is how I felt.*

*I felt really conned."*

Jill, interview 1

*"They [the staff] didn't have a clue...*

*I mean a lot of folk agreed that it was a waste of time being in there.*

*We didnae get as much help as we expected...*

*It kind of felt like,*

*if all you're getting is medication you could do that at home."*

Joanne, interview 1

#### 5.4.2 "Time out": A helpful aspect of being on the ward

Both Jill and Joanne describe the only helpful aspect of their admission as the time away from problems at home:

*"I did like the peace and quiet*

*because it gave you time to think about things eh,*

*but I would have liked something to do*

*rather than being on my own."*

Joanne, interview 1

*“...the only thing I benefited from there I feel was the time out factor, to remove me from the situation I was in.*

*I mean, because I don't feel any other, I didn't feel I got any other support.”*

Jill, interview 1

Having time away from dealing with the pressures of life outside the ward gave Jill and Joanne the opportunity to reflect and experience a decrease in stress as they no longer had to take responsibility for what went on outside the ward. This experience of being helped by virtue of removal from their daily life situation is picked up in Chapter Six where it constitutes a form of safety experienced by participants.

Thus, the overwhelming experience that was verbalised was one of disappointment when expectations of help were not met by the reality of being on the ward. In response to the perception that they were not getting the help they needed, or wanted, participants' narratives indicate that they turned to each other for support to fill this void.

## **5.5 “We did more counselling of ourselves...”: Participants supporting each other**

### *5.5.1 Introduction*

Participants developed strategies to support each other in their perceived absence of support from the nurses. Many of them narrated episodes where they found talking about their problems with other patients beneficial. However, some participants experienced listening to others' problems as burdensome. The relationships that patients developed with each other were experienced as both supportive and creating a vulnerability to getting hurt.

### *5.5.2 Filling the void: Participants' responses to the perceived lack of available help on the ward*

Several of the participants narrated stories about providing and gaining support through talking to other patients. In the following narrative excerpt, James clarifies

that the reason this form of support was necessary was the perceived lack of support from the nurses:

*“I think there were 4 or 5 of us perfectly understood  
that we weren’t getting much help,  
and therefore our best bet was to sort of support each other,  
which is what happened”*

James, interview 1

Jill also linked seeking help from the other patients to her experience that the staff did not spend time with her:

*“And the only other good thing I felt that came out of it  
was some of the people I met who were in similar situations to me  
really helped me  
we laughed about things.*

*In fact, we  
I mean, this sounds dreadful  
But we were laughing about things like, you know  
Somebody new’s come in and one of them’s [other patient]  
‘oh, there’s another loony’ you know  
and that sounds really bad  
but it was very, sort of, light hearted  
sort of jokey*

*because nobody really spoke to me,  
none of the staff.”*

Jill, interview 1

Throughout Jennie’s interview she referred to the lack of time that the nurses have and the impact of this on their ability to get to know the patients. Through her narratives she implied that because the nurses didn’t have time to spend with the patients, the patients had to help each other:

*“Only patients get to know what is really wrong with people  
because nurses don’t have time to spend getting to know them.”*

Jennie, interview 1

### 5.5.3 *“I felt it was beneficial...”*

Many participants found talking to other patients was helpful because it decreased their sense of isolation either by helping them feel part of a group, or through a sense of empathic understanding. Both Josie and Connor referred to the benefit they found in knowing that they were not the only ones who experienced their particular problems:

*“...if you were upset,  
they [other patients] would sit and listen  
and then they would say,  
well I sometimes feel like that*

*and you would feel a lot better  
because you would think,  
‘well it’s not just me.’”*

Josie, interview 1

In his narratives Connor refers to his experience of talking to other patients about his problems as *therapy*. His use of such a term implies that he perceived it as providing for his needs and making him feel better:

*“In the smoking room  
everybody comes into the smoking room and chats to each other  
and I thought this was my therapy, yeah?  
Because I’ve got a bloke sitting next to me talking about alcoholism  
If it was my pals outside I wouldn’t be talking about it  
because I wouldn’t want to talk about it*

Me: So it’s kind of like you’re allowed to speak about your problems then?

*Yeah, it’s brilliant,  
and I found it the best therapy I’ve ever had  
  
and they’re telling me all their experiences  
and I’m telling them mine,  
and I feel braw telling them...”*

Connor, interview 1

#### 5.5.4 *Mutual support: not beneficial for all*

Within the data, a number of limitations to the benefits of supporting each other are made visible. Some participants felt burdened by the problems of others, whilst some were isolated from these support networks because of their non-smoking status. The development of supportive relationships with other patients was dependent on the personalities of the patients who were on the ward at the time. Further, the development of such relationships left participants vulnerable to getting hurt when one of the parties within that relationship was no longer on the ward.

5.5.4a *“You end up taking on a load of other people’s problems”*: Whilst most participants recognised the benefits to themselves in talking with others about their



problems, both Jill and Jennie made reference to their experience that they had taken on other people's problems.

*"I, I didn't, I mean  
I went under tons of times in the acute ward  
because I would end up talking people through their problems  
and trying to help them  
and trying to help them,  
give them a grasp on some sort of reality.*

*People would just come up to me and talk to me,  
I don't know if it's my face or something.  
I ended up just talking to people.*

*And that's exhausting  
because you end up taking on a load of other people's problems.  
It's very exhausting  
24 hours on an acute ward.  
It's very exhausting."*

Jennie, interview 1

*"She [other patient] did come in and say hello,  
then proceeded to tell me her full history  
and at that time I was just like (sighs)  
'I have enough to cope with, I,  
at this time I just can't...' you know."*

Jill, interview 1

5.5.4b "...in the smoke room": Much of this support occurred in the smoking room, a location into which the nurses did not often venture:

*"We did more counselling of ourselves in the smoke room..."*

James, interview 1

*"In the smoking room,  
everybody comes into the smoking room and chats to each other..."*

Connor, interview 1

However, for those who did not smoke, there is a sense of isolation expressed in their narratives:

*"I didn't smoke either,  
and there seemed to be this big hub in the smoking room..."*

Jill, interview 1

*"There was a smoking room  
and it was like they were never out of there.  
Och, they were all saying, 'come on in',*

*and I'm saying, 'I dinnae smoke'  
so I was sort of isolated from them."*

Ewan, interview 1

In neither of his interviews did Ewan talk about developing relationships with any of his fellow patients. It may be that his non-smoking status, and his lack of desire to enter the smoky atmosphere diminished his opportunities to tap into the support that the other patients offered each other.

Cathy observed that even patients who did not smoke entered the smoking room, implying that the draw of the support of the patient group was great enough to encourage non-smoking patients to tolerate the smoky atmosphere:

*"What you find is  
the non-smokers come into the smoke room  
and they didn't smoke a cigarette,  
and I think that must have been very disgusting for them.  
And eh, they leave the fresh air environment and come in*

Me: Because that's where the social chat is and the support?

*yeah, it's funny, but that's what happens,  
that's what they do."*

Cathy, interview 1

**5.5.4c Personality as basis for relationship:** The relationships formed on the ward were formed in response to participants' needs for help, and safety. Whether or not participants were able to form satisfactory relationships with those around them was partly due to the manner in which their personalities fitted together. Amanda refers to a helpful relationship she formed with a fellow patient:

*"I walked every night with a fellow patient  
who pushed me,  
he made me walk in many ways  
and I did it for him as well as myself  
because we conversed, we just clicked,  
we were common interests or whatever."*

Amanda, interview 1

The relationship that Amanda refers to above developed because of the fit of the personalities of both parties. Jill also formed a close relationship with two fellow

patients. In her narrative she acknowledged how lucky it was that she was in the ward at the same time as two patients with whom she got on well.

Becky, on the other hand, felt that during this admission the other patients were more aggressive and violent than she could cope with, and this had prevented her from forming relationships:

*“...it was just on that ward,  
I mean, the people on that ward at that particular time were quite violent, quite  
em,  
they weren’t the kind of people I would normally go about with.  
Em, and I just think, em, they just, they just weren’t my kind of people.*

*But I avoided them,  
that’s the other thing,  
that was the other thing too,  
I avoided them.  
I avoided places like the smoky,  
or anything else,  
and that’s why I hung about the nurses,  
because I couldn’t stand the patients.”*

Becky, interview 1

*5.5.4d Vulnerability in close relationships with other patients:* As participants supported each other, the relationships they formed became close. However, whilst the closeness of these relationships was necessary for supporting one another, it also placed participants in a vulnerable position when one party was no longer on the ward.

Reflecting on the death of one of the patients with whom James had developed a relationship, he is struck by how quickly they grew close:

*“One of that group has actually  
since gone on to kill himself,  
unfortunately,  
which is quite upsetting.*

*You know, even though I only knew the guy for ten days,  
because we did end up so close,  
it was quite upsetting to hear about  
they let him go.”*

James, interview 1

Robert talked about how difficult it was when people with whom he had formed a bond were discharged before him:

*"I feel quite upset  
I feel sometimes you go onto the ward,  
you build friendships with the others,  
and more often than not you don't see them again.  
It's a brief interlude in your life,  
brief relationships."*

Robert, interview 1

Becky too implied this as she described how she stopped making friends in order to protect herself from the impact of forming and breaking relationships. She later described the situation of being left on the ward when friends were discharged as "a kind of limbo":

*"When you first go into a ward you, you em,  
you make friends with people round about you.  
But eventually they all get better  
and if you're still left there  
the making friends with people mechanism, em,  
kind of shuts down."*

Becky, interview 1

A further means of protecting themselves was described by Jill in her narratives. Keeping their talk on a superficial level, not delving into anybody's personal lives allowed patients to keep themselves safe:

*"And again, although with the other patients that were there at the same time as  
me,  
although we chatted it was very superficial.  
Everybody had problems.  
You don't talk about other folks' problems.  
You don't talk about families.*

*So everything that you talk about with them is for the moment,  
things you're experiencing at the moment.*

*But not, nobody had anybody's pa[st],  
it's all very, there's just a kind of unspoken rule,  
well I felt you could never ask any,  
because you just didn't know,  
you just wouldn't ask anybody anything really."*

Jill, interview 1

The data therefore illuminate the closeness of the emotional bonds that developed between patients as they supported each other. These are perceived as consequences of the situation in which participants found themselves, with an unmet need for support. Strong emotional bonds formed quickly due to the intensity of the situation, and there is an acknowledgement in some of their narratives, that these bonds would not survive outside the ward situation. The transient nature of these relationships led participants to focus on the here and now as a way of protecting themselves.

## **5.6 Summary**

During their interviews, participants told narratives that related their expectations and experiences of getting help by being on the acute ward. Participants were admitted onto the ward carrying expectations that they would receive help there. For the most part, this help was envisaged as taking the form of interaction with the nurses. However, from their narratives it becomes clear that participants did not experience the amount of interaction that they had hoped for with the nurses. Nor was this interaction generally initiated by the nurses, leaving the participants to feel that the nurses were not interested in, or did not care for, them.

Although stating that participants could talk to them whenever they felt they needed to, the nurses were seldom perceived to be available. Through their narratives, the participants imply that their experience was often that the nurses were too busy to talk. This generated feelings of frustration for participants most of whom expressed the need to talk with the nurses.

In response to this frustration at being unable to access the help they needed, the participants formed supportive relationships with other patients. Despite finding this generally beneficial, they experienced some detrimental effects of this. This mutual support however, could not fulfil all the needs of the participants, as there were boundaries that needed to be maintained in order to protect themselves from emotional harm.

Participants seemed to find themselves in a particular conundrum. That is, they were aware that they were unwell, and they got admitted to the acute ward with the

expectation that something would be done on the ward to make them better. The participants imagined that the nurses, through their interactions with them, would provide the help they needed. However, they found that this help was generally not forthcoming because, despite the nurses' statements that they are available to talk, whenever the participants approached them, the nurses were too busy. In response to their perception that the nurses were not providing the help they wanted, the participants turned to their fellow patients to provide mutual support. Whilst this was beneficial for some, the development of relationships with other patients left the participants feeling emotionally vulnerable. Thus, in trying to get help, participants, who were patients on the acute ward because of their poor mental state, were pushed into relationships with other patients which they felt had the potential to damage their mental health still further.

## 5.7 Discussion

The data presented in this chapter highlight the gap between participants' expectations of help, and the help that they received whilst on the acute ward. For many participants, admission to the ward was infused with hope and expectation that something would happen on the ward that would help them to regain their mental health. Participants perceived admission to the acute ward as a symbol of the acuteness of their illness. Implicit within the admission experience was the perception that those referring participants to the acute ward were indicating that hospital was the best place for the individual to get help. The data indicate that participants interpret 'help' in terms of therapeutic input; that by going into hospital they will get help to feel better. This resonates with the following passage from Chamberlin (1999:172):

*"Hospitalization [sic] was the next step. Perhaps a few weeks earlier I would have rejected going to hospital; now, it seemed inevitable. The logic seemed clear and irrefutable: if I had an illness, and it wasn't getting better, obviously more intensive treatment was required. I entered the hospital...sure that here, at last, someone would know how to make me better."*

However, within the policy literature, it is not therapeutic aims, but risk management that is the trigger for consideration of admission to the acute ward (see section 2.2.32) (Scottish Executive, 2006b). Thus, when practitioners recommend admission to

hospital it may be in response to their risk assessment, and their perception that the patient will be safest in hospital. Help in this instance is conceptualised differently to the participant's concept of help, creating different expectations.

The treatment most anticipated was talking; participants expected that nurses would want to talk with them about their problems. Chamberlin (1999: 172) expresses this expectation thus:

*"It seemed odd to me that no one on the staff seemed concerned with my feelings and opinions of what was wrong ..."*

Like Chamberlin (1999) in the above quotation, participants found that nurses did not actively seek to talk with them. They were instead faced with a system whereby they were expected to approach the nurses when in need of support. Participants described their attempts to interact with the nurses in terms of the barriers they experienced.

As a consequence of the barriers experienced when trying to access support from the nurses, most of the participants described relationships that reflect the negative pattern described by Coatsworth-Puspoky et al (2006) in their investigation of the nurse-patient relationship. These researchers identified three phases that occurred in the nurse-patient relationship, each is identifiable within the data. The first phase, that of withholding support is identified through the participants' perception that the nurses were unavailable. Through being too busy the nurses withheld support from the participants. During the middle phase identified by Coatsworth-Puspoky et al (2006) patients avoided the nurses, and perceived the nurses as avoiding them. Avoidance is perhaps most evident in the data as the participants turn to each other, rather than the nurses, for support. Through the lack of availability of the nurses, and the lack of interaction with patients, the nurses were perceived as ignoring the patients' requests for help. This feeling of being ignored is most clearly illustrated in Jill's narratives where she repeats her perception that it was obvious that she was upset, yet none of the nurses came to offer her help. The feelings expressed by participants that the nurses did not care, or were not interested in them; that they did not listen to the patients; and that the nurses had neglected or rejected them resonate with Coatsworth-Puspoky et al's (2006) findings. Attempts to try and make sense of their experience of relating with the nurses form the final phase of the relationship:

*“By comparing their experiences with what they thought was supposed to happen to them, clients attempted to make sense of the nurses’ behaviours and the lack of support they received.”*

Coatsworth-Puspoky et al, 2006:352

Within their narratives, participants offer up many reasons for the dissonance between their expectations and experience of their relationships with the nurses. Many of these explanations draw on a discourse of nursing shortages, leaving wards short staffed, and nurses without time to spend with the patients. This is evident in many of Jennie’s narratives as she explicates her perception that the nurses are trapped in the ward routine and therefore not able to spend time getting to know patients. The lack of support received in this relationship with the nurses resulted in frustration and anger, alongside anxiety and a sense of hopelessness.

However, not all relationships between participants and the nurses followed this negative pattern. Participants identified particular nurses with whom they experienced positive relationships. The defining characteristic of these positive relationships was the giving of time by the nurse, a finding that resonates with Moyle’s (2003) study of the factors that contributed to patients feeling nurtured. These relationships, however, are generally described as one-off incidents, where a nurse took time to be with a participant, taking an interest in them, listening to them. They are not described in the participants’ narratives as ongoing positive relationships, which developed to allow the participant to explore their problems. As such, they resemble what Altschul (1972) identified as passing relationships, stopping short of categorisation as therapeutic relationships.

The nurses were perceived to be unavailable primarily because they were too busy. The tasks that the participants perceived the nurses to be busy undertaking when they stated that they were too busy to talk, were generally not clinical but administrative. Instead of spending time talking with the patients as the participants had expected, the nurses spent their time undertaking what some participants perceived as non-nursing duties. In particular the amount of time that the nurses spent in the office doing paperwork was noted. Whittington and McLaughlin (2000) found that the nurses in their study spent more than half of their time carrying out administrative and



housekeeping tasks<sup>12</sup>. The nurses' lack of desire to interrupt these tasks to attend to the needs of the patients led to the patients feeling frustrated and rejected; the perception was that these tasks were more important than their needs. If we consider Coatsworth-Puspoky *et al*'s (2006) work, the absorption of the nurses in these tasks, which do not involve interaction with the patients, may be conceptualised as providing them with the means of avoidance identified as the middle phase of negative relationship development.

Experiencing the nurses as unavailable, and disinterested in helping them, the participants turned to each other for support. In their autobiographical writings both Chamberlin (1999) and Lindsay (1996) talk of the support they gained from other patients whilst in psychiatric hospital wards. Group theorists have long observed that in the face of adversity an assembly of people will form a group, melded by a common purpose (Douglas, 1995, Thompson, 1999). The participants in Thomas *et al*'s (2002) study described their experience of being part of the patient group in terms of solidarity; patients cared, and looked out for each other. Resonating with participants' experience within this study, Thomas *et al* (2002: 104) conclude that:

*“Universally, patients perceived their peer-administered “therapy” in the smoking room as the most beneficial aspect of their hospitalisation.”*

Relationships formed between patients on the ward for the purposes of meeting their needs, differ from those developed out-with the ward, because of the intensity of the environment and lack of alternative resources. The formation of relationships in this situation offers patients little time to get to know each other, as their need for support quickly leads to the formation of a degree of closeness. However, these relationships are born out of the situation in which patients find themselves, they have no history or future out-with the bounds of the present situation. Participants who had previous experience of being on the acute ward acknowledged the brevity of these relationships, and the emotional turbulence created by constantly forming and ending relationships. There was no knowing how long the relationship would last; discharge was often sudden (see Chapter Seven) offering little opportunity to attend to the need for closure.

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<sup>12</sup> other studies have also supported these findings. See Higgins *et al*, (1999); Clarke & Flannagan, 2003

Whilst supporting others was experienced by some of the participants as burdensome, it offered the opportunity for participants to occupy a meaningful role and gain a sense of purpose. In relation to Binnema's (2004) work, the ability to develop a meaningful role within the ward is a means of combating boredom. It also allows patients to use skills and knowledge gained outside the hospital, allowing the patient to develop his or her identity beyond the patient identity. Goffman (1961) identified the ability to retain a sense of one's identity as the means through which a patient can defend against the institutionalising effects of hospitalisation.

The data considered within this chapter make clear the participants' expectations that the help offered when on the acute ward would be in the form of talking with the nurses. Through the data it is evident that what participants wanted and needed was to experience this nurse-patient interaction as caring. They perceived that this attitude would be evidenced through the nurses' focus on developing a relationship with the patient, attending to his or her needs. This vision of what nurses should provide is not new, it is the vision of those who perceive the nurse-patient relationship as central to mental health nursing (cf Peplau, 1988; Altschul, 1997). It is also the vision of mental health nursing as described within *Rights, Relationships and Recovery* (Scottish Executive, 2006a) the report of the review of mental health nursing in Scotland. What participants convey through the data is their desire for mental health nursing to be focused as follows:

*“Mental health nursing is fundamentally about people, about spending time with people, and about developing and sustaining therapeutic relationships with service users and their families and carers.”*

Scottish Executive, 2006a: 14

The centrality of the nurse-patient relationship to the participants' experiences of being on the ward is evident in the data presented in the next chapter. Within their narratives about being safe on the ward, participants once again focus on the nurses as those whom they expect to keep them safe.

## **6 Safe Inside These Four Walls? Participants' Narratives About Being Safe On The Acute Ward**

### **6.1 Introduction**

Participants' interviews contained many narratives pertaining to their expectation and experience of safety on the acute ward. Within these narratives, participants conceptualised being safe as an implicit part of being a patient on a hospital ward; they expected to be safe. Their narratives indicate that there were three different expectations, or needs:

- ❖ To be safe from the world outside the acute ward
- ❖ To be safe from harming themselves
- ❖ To be safe from other patients

In the first part of this chapter I examine participants' narratives relating to these three categories of expectation/need.

The second part of this chapter focuses on the participants' expectation that it is the nurses' responsibility to keep them safe. Their narratives illuminate participants' expectations about how the nurses would deal with aggressive or violent incidents. Through their narratives they make explicit their knowledge of the resources available for dealing with aggressive patients. Knowledge of the available resources created expectations against which they evaluated the nurses' actions. Participants imply that they felt unsafe when the nurses' actions were not congruent with their expectations.

Gender becomes the focus of the third part of this chapter. Whilst the participants conceptualise the nurses as being there to keep them safe, they perceive male and female nurses as possessing different approaches and skills for keeping them safe. Within their narratives there is evidence that participants are drawing on a discourse where males are conceptualised as strong and able to afford protection against physical threat, and where women are themselves vulnerable and in need of protection. Through their narratives, participants make the relevance of this discourse explicit, and indicate its impact on their experience of being a patient on the ward.

Participants' narratives therefore reveal a tension between the expectation that the four walls of the acute ward will provide a safe haven for them, and the experience that at some point on the ward they feel unsafe. Their narratives indicate that they employ a number of strategies to enable them to feel safe, and these are the focus of the final part of this chapter.

## **6.2 “You’re safe enough in here”: Expecting to be safe on the ward**

### *6.2.1 Introduction*

Through their narratives participants conveyed their expectation that they would be safe on the acute ward. Being kept safe was considered to be a patient's right by Cathy:

*“I think that they should have a patients’ charter.  
That’s the thing that I thought was missing.*

*A patients’ charter to say that I’ve got the right,  
if I’ve volunteered to go into this hospital,  
I’ve got the right to feel safe.  
And that applies to people who might fear me.”*

Cathy, interview 2

Through their narratives, it was evident that participants perceived the need to be protected from the world outside the ward, from themselves, and from the other patients on the ward. Whilst their narratives generally conveyed a sense of being protected from the outside world, there was ambivalence about the ability of the ward to protect patients from harming themselves. However, the main focus of many of the narratives about being safe on the ward was the need to be kept safe from other patients on the ward.

### *6.2.2 Protected from the outside world*

The concept that being on a hospital ward would provide him with the safety he required was what drove Peter to go to the lengths he went to be admitted to the acute ward (see 5.2.3). During his first interview Peter told a lengthy narrative about how he came to be on the acute ward. Feeling increasingly paranoid, Peter decided he was no longer safe at home and needed to be in hospital. His GP did not feel he was ill enough to merit admission and so Peter decided that to get into the ward he would

have to get arrested and be taken to hospital. He describes how he felt when he was finally arrested by the police, expecting to be taken straight to the acute ward:

*“I didn’t know what to think apart from  
‘I’m safe,  
brilliant.’”*

Peter, interview 1

During one of her narratives, Amanda talked about reminding herself that she was “safe enough in here”, implying that she conceptualised the hospital ward as providing a safe environment.

In a similar way, Connor expressed his sense that he was safe from people outside when on the acute ward:

*“Naebody could get at me when I’m in there sort of thing when,  
I just, everything’s just fine”*

Connor, interview 1

Ewan described the feeling of safety that arose from not having to interact with the world outside the ward. He referred to the ward as a “safety valve” at several points during his first interview. Here he describes the tension he experienced between not being able to cope with the outside world, the refuge offered by the acute ward, and his desire not to be in hospital:

*“But within the unit,  
sometimes I felt safer within the unit  
than I did if I was wandering about.*

*My brother was,  
he used to come and see me all the time  
But you would sort of, want to get back, ken  
to a sort of, safety valve*

Me: right, so if you went out, say with your brother or something, then you would kind of feel some anxiety for wanting to get back to the ward?

*Aye, yeah, and once you got back in like,  
you were sort of,  
you felt better for being there.*

*But saying that,  
once you were there  
you were sort of wanting out,  
but you couldn't really handle too much, ken,  
outside"*

Ewan, interview 1

In the above quotation, Ewan is discussing the ward's function in protecting him from the stresses and strains of life outside. Jill and Joanne refer to this function of the ward as one of the main ways in which they felt that being on the ward helped them feel better (see 5.4.2):

*"I think to be totally honest with you  
it was actually,  
the being removed from a really stressful situation,  
and the time out*

*That had actually been taken right out my hands,  
there was nothing I could do  
So that time out was, obviously  
what I really needed."*

Jill, interview 1

### 6.2.3 Safe from themselves

Some participants verbalised the expectation that the role of the acute ward was to keep patients safe from harming themselves. The completion of a suicide on the ward during the period of data collection may have increased participants' consciousness of this role of the ward.

James recognises the role of the ward in keeping patients safe from harming themselves as being laid out in the Mental Health Act. He makes this explicit as he remarks that suicidal intent is one of the criteria for detaining a person in hospital under the auspices of the Mental Health Act:

*"And the thing is, if I tried to commit suicide or eh,  
they would section me."*

James, interview 2

However, in a previous narrative James had described his unease when his assumption that he was safe from harming himself on the acute ward was called into question by the suicide of a fellow patient:

*“But again, it’s one of these things that,  
when you’re in [name of acute ward], that you’re thinking about  
‘well, at least I’m safe from not doing something on that scale<sup>13</sup>  
either to myself or to other people.’*

*Like I say, that’s one of the patients has killed himself...”*

James, interview 1

The expectation, that a person will be safe from harming themselves whilst a patient on the acute ward, was also implied by Amanda. Narrating the events of the past week during which a fellow patient who was still resident on the ward had committed suicide, she repeatedly used the phrase *“the system has failed him,”* conveying her sense that this should not happen if a person is under the care of the hospital. Her anger was tangible as she stated:

*“And incredibly infuriating ahm,  
that he was supposed to be safe, you know,  
and how bad he was  
and no-one kind of picked up on it*

*But that was his third attempt like,  
which even makes me cross,  
the fact that he had attempted to do it in the ward about a month ago.  
So he was a high risk patient.”*

Amanda, interview 2

However, Amanda’s ambivalence about the ability of anybody to stop a person who is determined to commit suicide is apparent in the following excerpt:

*“Nobody could have, you know,  
having been there,  
nobody could have saved me,  
because I was clever in how I did it*

*Unless you’re in that position  
nothing’ll stop you.  
And you become devious,  
and your planning, as his obviously was...”*

Amanda, interview 2

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<sup>13</sup> Referring to media story of ex-soldier with mental health problems who had killed his family and then committed suicide.

In the above excerpt, Amanda initially seems to be stating that it is impossible to stop someone from committing suicide. However, she begins by stating that *“having been there, nobody could have saved me”* which does not fit with the reality that she was indeed saved and lives to tell the tale. Thus, underlying her statement that it is impossible to prevent suicide, she is also implying that it is possible to stop people despite their deviousness and planning. It is perhaps her knowledge that it is possible to stop someone who is actively suicidal that created the expectation that the ward staff should have been able to prevent her fellow patient’s death.

#### 6.2.4 *“You don’t know what anybody’s in for”*

Whilst participants experienced a sense of being protected from the world outside the ward, their narratives implied that they felt threatened and unsafe in the presence of some of the other patients. Much of these feelings arose from participants’ beliefs about people with mental illness being volatile and aggressive. These beliefs left participants feeling that they would be unable to predict others’ responses to them. In order to act on these beliefs, participants had to objectify the other patients on the ward, viewing them as different to themselves. This process becomes visible through their reference to the other patients as *“the patients”* (Amanda) or *“that type of patient”* (James) or *“the inpatients”* (Connor).

Jill talks about the pressure she experienced when trying to deal with other patients on the ward:

*“And then, you know, again you were very aware that you don’t know how to react with other people.  
You don’t know whether to look at them,  
whether not to look at them.  
You can’t ignore somebody,  
will that upset them, you know.  
That is a, I found that really, really quite difficult.”*

Jill, interview 1

James narrates the issue from the point of view of his anxieties prior to being admitted. His use of the past tense in his initial statement can be inferred to mean that, as he spent time on the ward, this fear began to diminish:

*“I had a big fear before I went in.  
And again, because I didn’t know the people that were in,  
or what they were in for or that,*



*you know you could say one wrong word to someone and it can set them off,  
there's that type of patient in there,  
I'm well aware of that."*

James, interview 1

In his interview John's narratives implied his intolerance of his fellow patients whom he viewed as *"blethering a load of rubbish"*. Initially he was unsure how to react to these stories but, like James, with time spent on the ward he gained confidence in his ability to interact with the other patients:

*"...and you would pass another one  
and they would say,  
'I never said that about you,'  
and you would say, 'I never said a word.'*

*But then I just started,  
when I kent there was nothing to worry about,  
I just started laughing at their stories."*

John, interview 1

Finding themselves in a position where they had to share a dormitory made participants feel vulnerable because they had no knowledge of the others next to them.

Jennie comments:

*"I was in a dorm.  
If you're in a dorm it's eh,  
if you're in a dorm it's very difficult because  
you don't know the state of mind of other people."*

Jennie, interview 1

The anxiety created by not knowing who you were sharing a dormitory with, was exacerbated by the lack of physical protection available to participants whilst in their bed space:

*"This is a massive mental issue.  
You're wanting me to move in with five other strange males,  
only protection being like a pull round cloth.  
I said, 'I don't want to do this.'*

*And it took a lot of talking to me  
and calming me down."*

Peter, interview 1

Thus, whilst participants expected the ward to be a safe place, the sense of safety described by most is safety from the outside world. The ability of the ward to keep

people safe from themselves was questioned. The assumption that the hospital ward was inherently a safe place was also challenged.

### **6.3 “That’s your job”: Expecting the nurses to keep patients safe**

#### *6.3.1 Introduction*

Analysis of the participants’ narratives makes visible their expectations that it is the job of the nurses to keep the patients safe. Through their narratives participants conveyed their expectations of how the nurses would deal with patients who were exhibiting aggressive or violent behaviour in order to maintain the safety of others. These included the transfer of violent patients to the secure unit, and acting on observations in order to prevent violent incidents. When the nurses’ actions did not conform to these expectations, participants felt unsafe.

#### *6.3.2 “There is a secure unit for violent patients”: Evaluating the nurses’ response to aggressive incidents*

Several participants commented on the presence of the secure unit, and their understanding of its function. John understood the nurses’ response to aggressive behaviour as follows, differentiating between the response to verbally and physically aggressive behaviour. He perceives the nursing response to verbal aggression almost as a parent telling a child to behave. There is a sense in John’s narration of the nursing response to physical aggression that it is very final, there is no question regarding how it should be dealt with:

*“I hear them [other patients] shouting and swearing and keeping shouting at each other*

*I’ve seen a lot of the what do you call it,  
the real nurses likes of the senior ones,  
asking to tell them to behave themselves*

*But if they don’t,  
if there were a blow,  
somebody hits somebody else,  
they would go on the floor*

*That’s it,  
you’re in [name of secure unit] and that’s you.  
It’s actually locked up  
and you have to go about with security”*

John, interview 2

In the final four lines of the above excerpt, John conjures up images of prison with his references to *security* and being *locked up*, and supported by the sense of finality created by his use of the phrase “*you’re in [name of secure unit] and that’s you*”. John’s framing of violence in terms of patients not behaving themselves, implies that he perceives the nursing response to violent episodes, restraint and transfer to the secure unit, in disciplinary terms. In the following quotation, Ewan also implies that transfer to the locked ward is punishment for aggressive behaviour:

*“They’re [the nurses] there to help you  
and if you don’t make an effort they move you out*

*They [the nurses] can only do their best,  
and if you do a lot of damage or something  
you get moved out to the locked ward.*

*And this used to go round my head because  
I knew about this and I was worried in case I’d end up there,  
but it never happened.  
But the anxiety knowing about it”*

Ewan, interview 1

Participants’ narratives indicate that they used their understanding of the role of the secure ward as the basis for making their own judgements about what kind of behaviour merited a transfer. Having witnessed a fellow patient assault a nurse, Connor expressed his confusion about why the patient was still on the acute ward:

*“But I thought, if he’s doing that there  
he shouldn’t be in this ward,  
it’s an acute ward, eh?  
And [name of locked ward] for people who are maybe a bit more violent,  
yeah?”*

Connor, interview 1

Jennie recalled her and other patients’ concerns about a patient who was behaving violently being allowed to roam around the ward:

*“Well, there is a secure unit for violent patients,  
and we [the patients] felt he should have been taken to [name of secure unit].  
[Name of secure unit] is the secure unit for people who are reacting violently  
and [name of acute ward] isn’t.”*

Jennie, interview 1

Having developed some kind of understanding of the role of the secure unit, participants drew on this to evaluate the nurses’ responses to aggressive and violent

incidents that occurred on the ward. Whilst narrating an incident in which two male patients returned to the ward under the influence of alcohol, Cathy made the following evaluation of the nurses' handling of the situation:

*“And I really thought that they [the nurses] should either,  
if they [the drunk patients] were allowed back into the ward,  
they should have been put to bed.  
But that didn't happen*

*I felt it was a bad judgement on behalf [of the nurses],  
of course people are under,  
again I know the system,*

*if they're under section then they cannae put them out,  
they cannae put them oot the ward,  
but they certainly had facilities to put them into”*

Cathy, interview 1

In her narratives, Cathy struggles to allow the critical statements she makes about the nurses to sit alone, always offering possible reasons why the nurses did not fulfil her expectations, and this narrative is no exception. However, she ends her narrative in a way that leaves the reader/listener in no doubt about the impact of the nurses' lack of action on her sense of safety:

*“I certainly felt it,  
very intimidating,  
much so much so I wanted to leave the ward that night.”*

Cathy, interview 1

### 6.3.3 “You should have seen...”: Expecting nurses to act on their observations to prevent incidents from occurring

Jill narrated an incident in which she was nearly assaulted. Through the narrative she conveys her sense that the nurses should have prevented this incident. In her narrative, Jill emphasises her constant movement back and forth through the ward as she attempted to get away from her assailant in the build up to the incident. Following the incident in the dining room, she retreated to her bed where a nurse came to see her. Jill narrates the following exchange that occurred shortly after:

*“One of the staff came down, and said, ‘I thought you were upset.’*

*And I said, ‘well, yeah, I just can't handle that,  
I don't know how to handle that.’  
I said, ‘she's been stalk, she's been,*

*there's just been something,  
she's been on me'.*

*'You should have come and told us.'*

*I thought, 'no, I'm sorry,  
you should have seen that,  
that's your job.'*

*And he said, 'you know, we were watching her there,  
we could see'  
and he said, 'oh well, we'll keep our eye on things.'"*

Jill, interview 1

Jill made it clear that she expected the nurses to intervene when they observed her being followed. Her perception that the nurse was unwilling to take any positive action is captured in her narration of the nurse's response, "*we'll keep our eye on things*". This statement implies that the nurses did not perceive the situation as requiring their intervention, highlighting a gap between Jill's and the nurses' assessment of the threat that Jill was experiencing. As in Cathy's narrative (see 6.3.2), Jill felt unsafe when her expectations regarding the actions of the nurses to keep her safe were not fulfilled. At the end of this narrative she stated:

*"I can't stay in this place any longer.  
I've got enough things to worry about,  
without having to worry about the dynamics of things that are going on in here"*

Jill, interview 1

In his narratives, John too expressed his perception that the nurses did not act to close down potential aggression quickly enough:

*"I've never seen people getting that frustrated  
there was not one meal I had and there wasnae an argument  
I'm telling you, that's how bad it is, ken"*

Later in the interview John returned to this topic, commenting on the nurses' reactions to this arguing:

*"The bickering between patients  
I think should be more quietened down"*

*In [name of other acute ward] they'd let them all argue  
And then they'd let it go to a certain point  
and then they'd say, what do you call it  
'in [secure ward]'"*

John interview 1

Amanda also questioned the extent to which the nurses acted upon their observations. Through her narratives she implied that she expected the nurses to have observed how at risk a fellow patient was, and to have acted on these observations in order to prevent his subsequent suicide. In this excerpt she seems to be asking why, if the patients can see what is wrong with another patient, could the nurses, who are trained professionals, not spot it?:

*“How could they not have seen that?  
How could they not detect some of that?  
How could they not pull it out of him?  
And we all knew as patients.  
We all knew the façade that he was putting on.”*

Amanda, interview 2

The lack of congruence between the expectations of the participants and the actions of the nurses led to participants feeling unprotected when aggressive incidents occurred on the ward. Both Cathy and Jill, in their narrative excerpts above, indicate that they felt so unsafe that they did not wish to remain on the ward. For Amanda, the perception that the nurses did not keep her fellow patient safe left her feeling angry.

#### **6.4 “I was always glad there was a male on”: Participants’ perceptions of male and female nurses’ ability to keep them safe**

Several participants offered narratives that explicated a belief that male nurses were more likely to be able to keep them safe than female nurses. These narratives drew on a discourse that portrays males as strong and protective, and females as vulnerable. As a result, participants showed an awareness of whether there was a male staff member on duty, and linked this with how safe they felt.

In his narrative James noted how the hospital procedure for dealing with aggressive or violent incidents emphasised the concept that male nurses are better able to deal with such incidents, and by implication, maintain the safety of others. This emphasis on the male nurses’ role in maintaining safety increased James’ feelings of vulnerability when there were no male staff on the ward:

*“If there was trouble in any other part of the hospital,  
the male nurses in our ward were immediately bleeped,*

*so that they could go to where the trouble was*

*A bit of trouble kicking off in  
some other part of the hospital could end up kicking off trouble  
in our area.*

*And what are they going to do then, when there's none of the male staff there?"*  
James, interview 1

In the following excerpt from one of her narratives, Amanda implies that she also felt anxious about her safety unless there was a male member of staff on the ward:

*"Oh I was always glad there was a male on  
for that simple bit of security for me,  
my safety*

*And sometimes the night shift,  
there was occasions when there wasn't a male member,  
I thought 'oh bloody hell, he's going to go nuts.'  
And again, it was really self protection."*

Amanda, interview 1

A long narrative in Connor's interview explicates his perceptions of the abilities of male and female nurses to keep the patients safe. His narrative centres round two incidents; the first where a patient assaulted a male nurse, and the second when a male patient chased several female nurses, threatening assault. In the narrative passage where he discusses the assault on the male nurse, Connor is careful to inform the reader of the gender of the nurse, stopping himself mid sentence to insert this information as he obviously feels it is crucial to his story:

*"One of the nur[s]es,  
it was a man,  
now I heard the smack and I went over,  
and he [the nurse] had him [the patient] down like.  
And I went over and held his [the patient's] legs  
'til the rest of the nurses came."*

Connor, interview 1

In the above excerpt Connor makes explicit that despite being hit - Connor had heard the smack therefore we are to believe that an assault took place - the male nurse had managed to restrain the offending patient. Thus the male nurse is portrayed as strong, still able to function and protect others, and himself, even under attack. This can be contrasted with the following excerpt from the same narrative:

*"But the next time it happened  
we were in the smoke room*

*and five nurses went running past shouting 'help'.  
And I went out and there's [name of patient] coming traipsing up the, up the  
corridor.*

*And I says, 'this is not right,'  
I said, 'that's five lassies'.  
I says, 'who's here for to help them?'  
There was no protection for them at all."*

Connor, interview 1

In the above excerpt from his narrative, Connor portrays the female nurses as vulnerable and requiring protection. Whilst initially referring to them as nurses, Connor later refers to them as "*five lassies*", a move that strips them of their professional standing. These nurses/women are portrayed as vulnerable; there are five of them and they are not able to deal with one patient. Unlike the male nurse who is assaulted yet remains able to carry out his work by restraining the patient, the female nurses are only threatened with assault from which they are fleeing, an act not seemingly recognised by Connor as professional nursing. The implication of Connor's narrative is that the female nurses are not able to protect the patients because they require protection themselves.

Several stanzas later Connor makes his point, that it is only male staff who are able to provide protection against violence on the ward:

*"I mean, if he[the patient threatening assault] had grabbed one of they women  
he could break her neck easily.*

*And I found that a bit,  
there was nae,  
that shift had five women on it,  
and I don't think there was any males on that day."*

Connor, interview 1

In contrast to these narratives where participants explicate issues pertaining to the need for physical protection against attack, placing the emphasis on the presence of male nurses, Peter observes the extent to which the qualities of the female nurses helped calm patients. Peter told two narratives during which he described feeling unsafe. These incidents were not those where there was a physical aggressor present, but where Peter feared he might be attacked. At the end of each of these narratives,



Peter expresses the value of the female nurse taking time to talk to him and calm him down. He crystallises these ideas in his comment about his observations of how the female nurses calm other patients down:

*“Normally a female member of staff  
would come in with a cup of tea,  
or take them [other patients] into a quiet room and calm them down,  
and you thought, ‘these lassies have got their shit together.*

*They really know how to bring someone right down with a quiet  
supporting word.’”*

Peter, interview 1

The data provide some evidence that patients perceive the capacity of male and female staff differently with regard to keeping them safe. From the data it is apparent that the gender of staff members, and in particular the presence of male members of staff, had an impact on how safe participants felt.

## **6.5 Participants protecting themselves**

### *6.5.1 Introduction*

Participants described a number of ways in which they kept themselves safe. Relying on the relationships that they formed with other patients was one means. Participants talked about waiting for their friends before going for meals so that they were assured of somebody with whom they felt safe to sit beside. Others spent time in their bed space, pulling the curtains round for a sense of security. Spending time in other areas of the ward where they were secluded from other patients, such as the shower was a further strategy used by participants to give them a sense of safety.

### *6.5.2 Relying on relationships with other patients to stay safe*

The relationships that participants formed with other patients were perceived to offer them some sense of safety. When Jill narrated the incident where she was stalked, she explicitly tells the listener/reader that this was a day when her two friends were not present on the ward, implying that had they been, this would have altered how events unfolded. In a later narrative she explicitly states the sense of safety that being with her friends afforded her:

*“And there were two or three people that I was really wary about.  
One in particular,  
but there were a couple  
and I used to think, ‘oh, if I wait for Amanda and Alex’.*

*And you feel so childish,  
you’ve got enough to worry about  
without worrying about who you’re going to sit next to at the dining table.”*

Jill, interview 1

### 6.5.3 Taking refuge

Participants talked about taking refuge either in their bed areas or some other place where they could get away from the other patients on the ward. James talked about using both his bed and the shower as a place where he could feel safe:

*“I didn’t interact with the other patients for the first three or four days.  
It took me three or four days to be confident enough to speak to them*

*I just lay on my bed and read, and read, and read.  
I even pulled the curtains round  
to get that little feeling of security.”*

James, interview 2

*“I used the shower room as a sort of place of safety.  
When I went for a shower I was in there for over an hour.”*

James, interview 2

Ewan also talked about spending time on his bed to stay out of the way of other patients:

*“I just kept myself to myself,  
there was no hassle,  
you knew that there were a couple of hot heads  
but they would sort of flip off now and again”*

Ewan, interview 1

For Jill too, her bed provided her with a space where she felt relatively safe:

*“I was frightened of some of the other people who were in the ward,  
so the thought of coming out of my room  
and going and knocking on the [office] door  
was quite frightening.”*

Jill, interview 1

The data show that participants used geographical location and the presence of other patients to keep them safe from the sense of threat they experienced from other patients on the ward.

## **6.6 Summary**

In this chapter I have presented data relating to participants' narratives about being safe on the acute ward. Participants were admitted to the acute ward with the expectation that they would be safe. Their narratives imply that they experienced the ward as a place that kept them safe from the world outside. This protective function, a removal from the daily stresses of their lives, was experienced as a benefit of being on the acute ward.

Participants expressed the idea that patients would be safe from harming themselves whilst on the acute ward. The suicide of a fellow patient called this assumption into question.

Participants' narratives about feeling unsafe generally related to a sense of threat from other patients. Whilst some of these threats took the form of concrete incidents, most were unfounded in any incident, representing instead the participants' ideas about people with mental illness posing a threat. Participants expressed the idea that they might provoke some form of aggression through their response to another patient's interaction. These ideas appear to stem from beliefs that participants brought with them to their situation on the acute ward, beliefs that linked aggression and unpredictability with mental illness.

Participants focussed on the nurses as the people who would keep them safe. They expected the nurses to observe the build up of particular incidents, and intervene prior to any aggressive outburst. Participants also made it clear that they knew about the secure unit that was available for caring for those who were violent on the ward. Their narratives indicate that they made judgements about whether a fellow patient should be transferred to the secure unit, and evaluated the nurses' actions against their

own perceptions of what should happen. When the nurses' actions were not congruent with the participants' expectations, the participants verbalised feelings that they were not safe.

Expectations that the nurses would keep them safe were tempered by the participants' perceptions that the male nurses afforded them protection against physical threat, and the female nurses were less able to do so. Several participants expressed their feelings of vulnerability when there were no male staff on duty.

Experiencing a lack of safety on the ward caused participants to develop strategies to keep themselves safe. A common strategy was that of physically keeping out of the way of other patients, by taking refuge in a particular part of the ward. Despite its flimsy nature, the curtain around participants' beds afforded them some sense of protection. Protection was also gained from the presence of other patients with whom participants had some form of relationship. Whilst in the company of those they trusted, participants felt protected from other patients.

## **6.7 Discussion**

As in chapter five, the data considered in this chapter illuminate the dissonance between participants' expectations and their experiences of being kept safe on the acute ward. Indeed, the definitions of the role of acute care in Scottish policy include the management of risk to self or others (Scottish Office, 2007; Scottish Executive 2006b). Whilst the walls of the institution may provide a physical barrier between the outside world and that inside the ward, participants experience threats from within the ward itself. In the same way that the participants focused their expectations of help on the nurses, so in this chapter they focus on the nurses as those who would keep them safe; as in chapter five, there is a gap between expectation and experience.

Participants' narratives about feeling protected from the outside world resonate with the findings of other studies. Participants in *Acute Problems* (SCMH, 1998) and in Thomas *et al* (2002) report feeling protected by their placement within the four walls of the acute ward. These walls were perceived as protecting them from people who

caused stress in their lives. Being in the ward also meant that patients could get away from the daily struggles of living, and give over some of the responsibility for daily life. Participants in this study evaluated this protective function of the acute ward as helpful, giving them space to sort out their problems.

However, as Quirk *et al* (2004) note, this sense of protection was diminished by the experience of threat from within the ward:

*“The perception of the psychiatric ward as a place of safety during a time of crisis may nevertheless change over the course of a person’s stay, as he or she comes to terms with the risks that are concentrated in this environment.”*

Quirk *et al*, 2004: 2577

The source of this threat was the other patients; participants perceived the other patients as unpredictable and potentially violent. This perception of the other patients as threatening is supported by Quirk *et al*’s (2004) findings. Other studies have also reported the experience of the ward as threatening because of the other patients (SCMH, 1998; Cutting & Henderson, 2002; Kohen, 2001; Baker, 2002). However, this is often attributed to the mix of different diagnoses - substance use, neuroses, and psychoses - on the ward. The perception that other patients pose them a risk has two roots: firstly, tension in the ward atmosphere created by a patients’ actual threatening or aggressive behaviour; secondly, the perception that people with mental health problems are unpredictable and aggressive.

During their stay on the ward, participants observed the nurses dealing with aggressive incidents. Whilst the aggression displayed by the other patient made participants feel threatened, it was the nurses’ response to this aggressive behaviour that determined how safe they felt. Drawing on their knowledge of the available resources, and how previous incidents were dealt with, participants made judgements about the appropriateness and effectiveness of the nurses’ actions.

Participants’ based their judgements about whether the nurses had dealt appropriately with an incident on the perceived level of threat. However, when participants judged nurses not to have dealt with a situation in the way they expected it is possible that this is due to differing participant and staff perceptions of threat. In their study of patients’ and nurses’ perceptions of the acute ward environment in a Norwegian

hospital, Rossberg and Friis (2004) found that staff and patients perceptions differed with regard to levels of aggression exhibited by patients. This difference in perception may be caused by the staff's acceptance of an elevated level of aggression as a normal feature of the ward environment. Quirk *et al* (2004: 2577) noted that:

*“Some user-respondents commented that a certain level of antagonism was overlooked or even allowed by staff.”*

The above quotation resonates with John's observations that the staff would allow the patient “*bickering*” to continue beyond a level that was tolerable for him. Such differing perceptions of what is acceptable will lead staff and patients' perceptions about when to intervene, or even what constitutes an aggressive incident, to differ. These differing perceptions will lead to differing expectations with regards to the best way to deal with the incident. Thus, whilst patients may perceive that the aggressor should be transferred to the secure unit, the nurses may not perceive that the level of aggression fits with this action, and continue to deal with the situation on the ward.

The participants' perceptions that the other patients were unpredictable and potentially violent are also evident in the data. One cause of this perception is participants' lack of knowledge about the other patients, “*you don't know what anybody is in for*” (Jill), causing them to rely on the application of a discourse model (see section 3.3.3) developed from the discourse that associates mental illness to volatility and violence (see section 2.2.3). Despite the fact that the participant is a patient on the ward (the new situation), he or she does not apply the discourse model to him or her self. The participant's knowledge of himself allows him to make informed judgements about the risk he or she poses, but the lack of information upon which to make this judgement about others necessitates the application of the discourse model and thus, the generalisation across a category of people. This process occurs early in the admission, and as participants got to know each other (and therefore the generalisations were replaced by specific knowledge), there is evidence of this experience of threat diminishing (see James and John in 6.2.4).

Participants also based their perception of the threat posed by other patients on their assessment of risk. In the data they indicated that there were particular patients whom they would avoid because they experienced them as threatening. In their study, Quirk

et al (2004) noted that participants undertook their own form of risk assessment whilst on the ward, allowing them to take action to keep themselves safe.

As well as undertaking their own risk assessments, the participants in Quirk et al's (2004) study, as in this study, adopted particular strategies to protect themselves. Avoidance of patients who posed a specific threat (Quirk et al, 2004): finding a safe haven, for instance, James used the shower room as somewhere to escape to; and the use of de-escalation to calm a situation down (Quirk et al, 2004), as described by Connor.

Using their bed space as a safe haven has implications for the help that participants receive. In Chapter Five, participants highlighted the lack of nurse-initiated interaction as problematic for their relationships with the nurses, and ultimately reducing the sense that they were receiving the help they wanted. Isolating themselves on their bed means participants were less likely to come into contact with the nurses. Clarke and Flannagan (2003) noted that those patients who did not overtly request help were more likely to have their problems go unnoticed on the wards that they studied (Clarke & Flannagan, 2003).

The participants in this study, and in Quirk et al (2004), who used their bed space as a place of safety, found that sharing a dormitory compromised their sense of safety. In fact, some participants experienced sharing a dormitory as threatening to personal safety. This was an issue particularly pertinent to Peter whose history of abuse led him to feel threatened by the concept of sleeping in a dormitory with five other males. Whilst Peter's narrative raises issues about sensitivity to individual issues when applying standard ward procedures, it also raises general questions about the requirement that people who are suffering psychologically, and may already be feeling vulnerable and anxious, sleep in a room together with no protection round their beds.

Participants in this study expected the nurses to keep them safe whilst they were on the ward. However, they perceived male nurses as more likely to keep them safe than female nurses. Drawing on a discourse that portrays men as possessing strong and protective attributes, the participants indicated that they felt safest when there was a

male member of staff on the ward. The perception that male staff are more capable of dealing with aggressive incidents is also promoted by the NHS Trust policy that requires male staff to attend incidents on other wards. Watching the male staff rush off to incidents elsewhere in the hospital gives credence to the participants' general perception that male nurses are more able to protect them; participants expressed their sense of vulnerability at times when there was no male presence. Such perceptions are linked to the concept that aggressive incidents require physical intervention.

Within the literature there is a view that the use of interpersonal skills can both defuse, and prevent the escalation of, an aggressive situation (Irwin, 2006; Quirk *et al.*, 2004). Returning to the findings of Coatsworth-Puspoky *et al.*'s (2006) study, the consequence of developing detrimental relationships between nurse and patient was frustration, anxiety and fear. These feelings were also identified by participants, labelled by the nurses as 'difficult', in Breeze and Repper's (1998) study. Involved in relationships that echo Coatsworth-Puspoky *et al.*'s (2006) detrimental relationships, the participants in Breeze and Repper's (1998) study experienced a loss of control over their personal situation when on the ward. They responded to these feelings through aggressive and non-compliant behaviour.

It follows then, that the development of patterns of nurse-patient interaction where the patient feels valued will reduce the likelihood of aggressive behaviour. In their study of the impact of re-focussing nursing activity on developing positive nurse-patient interactions, Dodds and Bowles (2001) found that the development of positive relationships with patients significantly decreased levels of aggressive incidents on an acute ward. By decreasing the levels of aggressive incidents through focussing nursing on the development of relationships with patients it might be anticipated that patients would feel safer, and therefore less vulnerable when there was no male member of staff present.

Whilst much of the material within this chapter pertains to risk from others, participants also expected the ward to keep patients safe from their self-destructive impulses. This expectation was created by participants' awareness that they could be compulsorily detained in hospital if they were assessed as posing a risk to themselves. During the period of data collection there was a completed suicide on the ward, and



some of the participants were patients on the ward at that time. For these participants, this raised particular issues regarding safety. The suicide cast doubt on the assumption that the ward staff had the power to keep people safe. Again, the nurse-patient relationships was the focus as the narrative commented on the lack of nursing knowledge of the patient's mental state, echoing Jennie's perception that it is the patients not the nurses who know what is wrong with patients (see 5.5.2).

The completion of the suicide brought to the fore an issue that runs through this chapter, a question of whether the staff are able to meet the expectations of the participants that they will be safe whilst on the acute ward. The evidence from the data is that the participants often felt unsafe, and were unsure that the staff could keep them safe, hence the need to develop their own strategies for this. This raises a further question of whether an environment in which patients do not feel safe is conducive to promoting recovery from mental illness?

Within this chapter, as in Chapter Five, the experience of the participants is bound up in their relationships with the nurses. In the next chapter, I present the data pertaining to participants' perceptions of power relations within the ward, and in particular, the experience of power relations within the nurse-patient relationship.

## **7 Participants' Experiences Of Power On The Acute Ward**

### **7.1 Introduction**

In this chapter I examine participants' experiences pertaining to power relations on the acute ward. Participants spent time working out the ward hierarchy, noting the different power relations within the ward team. Data pertaining to this sense-making activity is presented in the first section of this chapter.

Participants' narratives indicate that they perceived the psychiatrist as having power over admission and discharge to the ward, and the patient's passage between these two phases. Presentation of these data forms the second part of this chapter.

The relevance of having worked out the power relations on the ward for the participants becomes clear through the participants' narratives about the nurses' role in observing and reporting on the ward. Participants perceived the nurses as the psychiatrist's agents, constantly observing them and reporting these observations so that the psychiatrist could make clinical decisions. It is therefore through the nurses' reports that the participants were known to the psychiatrist, so the content of these reports took on a significance for the participants. In response, the participants managed their self-presentation in order to influence the nurses' reports, and ultimately the psychiatrist's decisions.

The final part of this chapter presents data relating to the tension identified by participants in their relations with the nurses. Participants attributed these tensions to frustration at not receiving the help they needed, and the experience that, as mentally ill patients they had their accounts invalidated by those who are afforded greater credibility by society.

### **7.2 Participants' conceptualisation of the hierarchy of power relations on the ward**

Through their narratives, participants made their perception of the hierarchy of power relations on the ward (ward hierarchy) explicit. At the apex of this hierarchy was the

psychiatrist, considered to be the most powerful member of the ward team. His or her powers were perceived to extend across all areas of the patient admission, and were discussed in particular relation to the power to admit or discharge patients. The powers granted the psychiatrist through the Mental Health Act meant that he or she could admit, treat and detain patients against their will, an aspect of their power that did not escape participants:

*“Ken what they dae if they say you’re no fit  
and you say you’re going to walk out of here?”*

*They section you,  
that’s what they do  
if they, if they think you’re no fit,  
they’ll section you.”*

John, interview 1

In the absence of the psychiatrist, participants were seen by one of the other medical staff. These doctors were, however, conceived of as operating under the direction of the psychiatrist, as implied by participants’ references to them as *“their [the psychiatrist’s] doctor”*:

*“I’ve never actually spoken to the consultant,  
it was actually their [the consultant’s] doctor,  
and it was their doctor that made the decision to stay”*

Ewan, interview 1

Sitting beneath the medical team in the power hierarchy were the nurses who were conceptualised as carrying out their work under the direction of the medical team. Participants perceived the nurses’ main function as gathering information about patients, and acting as mediators between the medical team and the patients:

*“If you don’t like it you just lump it,  
because these staff [nurses] are just getting the word from the top;  
they can’t change it,  
they can’t do any feedback.”*

Peter, interview 1

Peter sums up his sense of the ward hierarchy later in his narrative:

*“’Cos I knew they [the nurses] would only know when I was ready for my discharge  
when they got word from their superior [name of senior house officer]  
who got word from his superior [name of psychiatrist].”*

Peter, interview 1

Whilst Peter implies that the nurses had no power within the ward situation, John acknowledges that nurses also have powers to detain patients under the Mental Health Act:

*“A charge nurse could section you.”*

John, interview 1

Participants experienced the nurses as needing to feel powerful in their own right, and exerting this power through their interactions with the patients. Peter describes how he used his perception of this need to manipulate the nurses:

*“Now I always used to ask,  
‘when am I going to see [name of psychiatrist]?’  
‘We’ll let you know.’  
‘You let me know, staff,  
that’s good enough for me.’*

*Make them feel that they’re in charge  
even though they’re getting their orders from above.”*

Peter, interview 1

From his experience of relating to the nurses, James also perceived that they expected him to remain in a less powerful position than them:

*“I wasn’t, I wasn’t going to let them walk all over me.  
And I think that’s what they expect,  
is that they’re in control, therefore,  
we should run about like scared rabbits  
doing everything that they tell us to do.”*

James, interview 2

The power of the nurses was therefore experienced as a proxy for the psychiatrist and medical staff, and as a means of asserting their authority over the patients. As an agent of the medical staff, the nurses were viewed as observers and reporters, their observations forming the basis upon which the medical team’s decisions were made.

### 7.3 The psychiatrist's power over admission and discharge

#### 7.3.1 Power over admission

For those participants placed upon a section of the Mental Health Act, the psychiatrist's power to admit them to the ward against their will was ever present. Robert was on a Compulsory Treatment Order (CTO) that, he perceived, allowed the psychiatrist to bring him into the ward if it was felt that his mental health was deteriorating. He refers to the process of admission as being "*recalled*" to hospital, and describes living with the knowledge that this will happen as follows, expressing a sense of powerlessness:

*"It's a bit like being in an open prison,  
that's the way I view it.  
My admissions to that ward have been like an open prison,  
it's been against my will,  
I'm not happy to be there."*

Robert, interview 1

This excerpt illustrates Robert's sense that he has no control over the process of admission to the ward; admission occurs when the psychiatrist, rather than Robert, feels it is necessary.

Josie's narrative about admission (see section 5.2.3) also illustrated how the psychiatrist holds the ultimate power over whether an individual is admitted to the acute ward. Through her narrative Josie implies that the psychiatrist did not listen to her pleas for help, and take seriously her expressions of need. The desperation she experienced led Josie to lose her temper with him, finally getting her a place on the ward.

Thus, whilst Robert's narrative highlights the psychiatrist's power, granted through the Mental Health Act, to have him admitted to the ward, Josie's narrative highlights how the psychiatrist used his power, and by not listening to her statement of need, attempted to keep her from being admitted. Thus, the psychiatrist was perceived to occupy a gatekeeping role as described by Connor:

*"Because you'll no' get into the psychiatric hospital unless you've been  
assessed by a psychiatrist..."*

Connor, interview 1

### 7.3.2 Power over discharge

Participants implied through their narratives that the goal of their efforts whilst on the ward was to get discharged. However, the psychiatrist was perceived as having the ultimate power over when patients were discharged, leaving participants feeling that they had to wait until the psychiatrist decided that they were well enough to leave:

*“It’s up to them [the psychiatrist] to tell you when you’re getting out.*

*And the last time I was in  
I was in for three weeks, and you’re sort of thinking,  
that’ll be three weeks tomorrow so that means I’ll be getting out on Tuesday.  
Then it doesn’t happen and you say, ‘well, how no[t]?’*

*But obviously, they’re no gonna let you go til you’re ready,  
but try telling that to yourself  
when you’re sort of been in there  
and wanting to get out.”*

Ewan, interview 1

*“I had to wait to see [name of psychiatrist] you see.  
They put me under another doctor you see,  
but they had to wait on [name of psychiatrist] saying for me to go,  
but I could have got out on the Wednesday.”*

John, interview 2

In one of his narratives John implies his constant awareness of the psychiatrist’s power over when he is discharged:

*“[N]ever fall out with them [psychiatrists].  
You always gi’e them their what do you call it,  
their title an’ that  
an’ their job*

*If you start arguing with them, ken,  
they’ll just do the very opposite  
keep you in longer  
or make it more awkward for you.”*

John, interview 1

However, whilst the psychiatrist could prolong a patient’s stay on the ward, several participants also referred to the lack of preparation they received regarding their discharge, resulting in them feeling unsettled:

*“The first time [first admission] the doctor says, ‘you can just go now’.  
I thought, that’s sort of, ken,  
you think to yourself, ‘I don’t want to go now,’ ken.”*

Ewan, interview 1

Josie had been persuaded by the staff to remain on the ward for a further week after her medication was changed. However, following an examination by the doctor on the ward, she was then told she could go home. In the following excerpt she describes how she told her husband who had come to visit her, and we get a sense of the impact of this unprecedented news on both of them:

*“Eh, I was all packed when my husband came up after lunch time  
and eh, I says, ‘that’s my husband here’  
‘oh, I’m sorry, you’ll have to wait to 5 o’clock for your medicines to come’  
So my husband says, ‘we’ll just go for a wee run in the car’*

*And eh, when he left me on the Sunday  
he says, ‘oh well,  
you’ve only got Monday...’  
he was counting the days*

*And so when I got in the car I says  
‘I’ve got news for you’  
and eh, I says, ‘I’m getting home today’  
and I got no answer*

*He couldn’t take it in  
He says, ‘but I thought it’s next weekend’  
and I says, ‘no  
they’re needing my bed  
so I’m getting flung oot.’”*

Josie, interview 1

Josie’s reference to her imminent discharge as “*getting flung oot*” gives a sense that she felt she was being discarded; that being discharged at that particular time had more to do with the needs of the ward than whether she was ready for discharge. The feelings of shock expressed by Josie resonate with those evident in James’ narrative below. James didn’t see the consultant during his admission to the acute ward, but saw the same doctor on two occasions. On the second occasion he was told that he was discharged. His narrative implies the shock and disappointment at being discharged:

*“Just discharged.  
You can go.  
There’s nothing we can do for you.  
Make your own way home.”*

James, interview 1

Like Josie’s, and Ewan’s, discharges, there is a sense that James’ discharge was unplanned and that he was expected just to make the transition back home. These narratives imply a sense of being returned back to whence they came with no consideration for the difficulties or anxieties that this might engender.

### *7.3.3 Discharge and voluntary status*

The majority of the participants in the study were admitted voluntarily. However, their narratives indicated that an official status as voluntary did not mean that participants had either been admitted to, or remained upon, the ward without experiencing an element of persuasion.

Joanne recalled a desire to leave the ward, having decided that she was not receiving the help she felt she needed. However, she remained on the ward for a further few days, persuaded by the nursing staff that this was in her best interest:

*“I was in voluntary*

Me: So what does that mean though?

*It means you can discharge yourself at any time.  
But I did speak about it [discharge] to them [the nurses],  
but the staff nurse there said it’s a bad idea,  
stay another night.”*

Joanne, interview 1

The idea that as a voluntary patient you can leave the ward when you wish is viewed as naivety by John:

*“Oh, you know, and they’re all saying,  
‘I could walk out here when I want.’*

*Ken what they dae if they say you’re no fit  
and you say you’re going to walk out of here?  
They section you,  
that’s what they do.”*

John, interview 1



James also perceived voluntary status as requiring some form of permission to be discharged:

*“Even if you go in voluntary you need a doctor’s, eh,  
permission to say you’re fit to return to normal society.  
And if there’s no doctor’s letter  
then you are an escaped mental patient if you leave.”*

James, interview 2

The data presented highlights the participants’ perceptions of the psychiatrist as having the power over admission and discharge to the acute ward. Whilst some participants experienced the psychiatrist as using his power to admit them against their will, others felt they had to fight to be recognised as requiring admission. Participants generally perceived that they must wait until the psychiatrist decided that they were ready for discharge, whether or not they were voluntary patients.

#### **7.4 Nurses’ observations and reports as the basis for the medical team’s decision making**

##### *7.4.1 “They observe you 24/7”: Experiences of being constantly observed*

The decision that the medical staff made about whether or not a patient was ready for discharge was conceptualised by participants as being based upon the observations and reports that the nurses made. Participants perceived that the nurses were constantly observing them, and that these observations were written into a file for each patient. Becky describes how she experienced this observation:

*“I think the thing that stands out most about being in the hospital, is  
that there was an incredible feeling, at one point, that  
you had absolutely no privacy.  
That, that there was em, you were being observed 24/7  
and there was nothing you could do  
that wasn’t noticed.”*

Becky, interview 1

The feeling that he was being constantly observed made Ewan feel “*paranoid*”:

*“You see, they [the nurses] watch you 24/7.  
Of course you’re paranoid,  
you’re like that [indicates paranoia with facial expression]  
but it’s just really to see how you’re reacting to the place”*

Ewan, interview 1

The paranoia that Ewan experiences in relation to being observed is testament to the importance that he places on these observations with regards to his passage through the acute ward. The last part of the above quote implies that Ewan comes to experience these observations as less threatening as time goes by. However, in a later narrative Ewan returns to the importance of these observations. His reference to the ‘*dossier*’ that the nurses compile conveys his sense that the content of their observations is secret:

*“They [the nurses] make a dossier about you,  
and obviously have their meetings and say,  
‘well, he’s no doing very well, maybe better stay in a wee while,’ or,  
‘he’s fine, we could maybe try him on a pass’.”*

Ewan, interview 1

During his narratives Peter made constant reference to the record that the nurses kept of their observations. The importance that he afforded this record is belied by the evaluative judgements he made about the things that would look good or not, on his record. These judgements were based upon Peter’s concept of what the staff would view as a good patient. For instance:

*“I thought, if I’m going to be observed,  
I want to be seen smoking a couple of fags in the smoking room,  
then say to the staff,  
‘right, I want to go outside for a walk and get some fresh air’.  
To prove to them I’m gonnae get myself fit.”*

Peter, interview 1

*“I thought that’s no good.  
If I start greetin’ in the middle of the dinner room,  
it’s just gonnae go on file  
and they’re gonnae think, ‘he’s no strong enough to go outside.’”*

Peter, interview 1

The anxiety exhibited by Peter in the above excerpt is due to his perception of the interpretive activity of the nurse as he or she transformed observation into a judgement about his mental health. It is what the nurses would *think* that was problematic, that is, how they interpreted Peter’s behaviour and gave it meaning. Such interpretive judgements are informed by the nurse or doctor’s knowledge,

beliefs, attitudes and experience, and as such are out-with the participant's control. In particular, some participants felt that the ward staff interpreted their reactions to events from within a mental illness framework, resulting in them designating 'normal' behaviours as signs of mental ill health.

This is illustrated by Robert who perceived the psychiatrist, and other health professionals, as misinterpreting what might be considered a normal emotional reaction to an event, in light of his label of mental illness:

*"If you ask the nurse to do something for you,  
or you get annoyed with the nurses for some reason,  
or you think that they're dishonest and you get annoyed with them,  
they interpret that as you being mentally ill.*

*It's not mental illness.  
I mean, people with mental illness generally speaking,  
that are psychotic,  
aren't allowed to be angry or lose their temper out-with their illness,  
that's part of their illness,  
it gets included in as part of their illness*

*So any normal reactions that are emotions,  
and extreme emotions of sadness and anger, that  
any normal reactions above or below the normal levels of sadness or anger, or  
any,  
can be a bit funny."*

Robert, interview 1

Becky also implied that emotional reactions to events were interpreted differently in light of a person's mental illness. She talks about learning not to react as a means of defence against the nurses' observations:

*"You have to learn eventually to take it on the chin.  
So things happen, there's nothing you can do about them.  
You mustn't let yourself be seen to be bothered."*

Becky, interview 1

#### 7.4.2 *The impact of being observed on participant behaviour*

As a consequence of the perceived importance of these observations, the participants described how they became aware of their self-presentation on the ward. They perceived the nurses as making judgements about how well they were, and therefore

whether they were ready to leave the ward, based upon these observations. Thus, for participants, it became important to portray themselves in a manner that they felt would most benefit them and allow them to realise their goal of discharge. Two strategies were evident within participants' narratives:

- ❖ Presenting themselves as a good patient
- ❖ Masking symptoms of their illness

*7.4.2a Presenting themselves as a good patient:* Participants talked about good and bad patients, implying that the nurses made judgements about what kind of patient they were from their behaviour. The implication was that, if the participants presented themselves as good patients, the ward staff would treat them better.

In the following excerpt from one of Peter's narratives, the elements that he thinks the nurses will value are made explicit as he lists what he plans to do in an attempt to be a good patient:

*"The only thing that I thought was,  
if I can be a good patient here*

*I thought, but if you can level out,  
keep your nose clean,  
take your tablets and let them know,  
this guy's wanting out;  
let them know, 'staff, when do you think I'll be ready for discharge?'"*

Peter, interview 1

Jill too implies that being a good patient involves acting in a way that was complicit with the nurses' wishes. This created a tension for Jill who found it difficult to comply when she felt that she was getting nothing in return, yet worried that she would be perceived as rejecting the ward if she went home:

*"Nurses can be quite quick to judge people  
and I didn't want to be thought of as being difficult.  
So I didn't want to upset the ward,  
I felt I wanted to comply with them.*

*But because they weren't doing anything for me,  
and also because I was so unwell,  
yes I desperately wanted to go home."*

Jill, interview 2

In Becky's interviews she refers to maintaining her "armour" in order to cope with the feeling of being observed. Becky's armour was a self-presentation that did not waiver from that which she perceived would be expected of somebody who was well. Thus, Becky invoked the concept of doing everything "by the book". Here she describes how she presented herself in the manner that she assumed met with the nurses' expectations of a good patient:

*"The only way to cope with that [being observed] is to do what is expected of you,  
is to do everything by the book.  
Because if you do it all by the book they [the nurses] can't get at you,  
nothing can, nothing can, hurt, hurt you.*

*So you do it all by the book.  
You keep your room tidy, you  
You get your clothes ready for going to the shower,  
you put your clothes on in the shower.  
You don't let any chink appear in your armour."*

Becky, interview 1

Being a good patient seemed to involve doing what you were asked and showing the nurses that you were working to get yourself better. Taking responsibility and showing that you were trying to get better was referred to by a number of participants as a means of presenting themselves as good patients.

John perceived that the nurses had a positive attitude toward those whom they saw were trying to help themselves:

*"And I think, if you're trying tae dae something in a place,  
in a hospital like,  
that they see that.  
They do see it.*

*They notice you want tae dae sort of thing  
and you're nae lyin' in your bed  
it makes them, them seein' that you're actually tryin',  
tryin' to achieve somethin', ken."*

John, interview 2

Peter described his belief that in order to get the care he felt he needed, he had to show the staff that he was behaving responsibly:

*“I’ve got to show the staff that I’m trying to behave myself,  
trying to get better, towing the line.  
Not trying to be like a perfect patient,  
but one you can trust.”*

Peter, interview 2

This idea that you had to show the staff that they could trust you also features in Ewan’s narrative:

*“If they’ve [the nurses] given you the trust,  
after the first three days you’re allowed outside  
and you get a pass to go further and further,*

*You know there was nothing stopping me from jumping on a bus  
and heading down to England or whatever,  
but if you do that you’ve broken the trust  
and when you get that trust you get, it’s ok.”*

Ewan, interview 1

Participants perceived the nurses as rewarding good behaviour by giving a pass<sup>14</sup> allowing the patient to go home for a period of time:

*“...[A]nd if you don’t muck about with them [the nurses],  
if you don’t give them a hard time they’ll say,  
‘well, Mr Smith’s quite good, he’s sticking in  
and in a few days he’ll maybe get a pass or whatever’.”*

Ewan, interview 1

Peter also perceived pass as a reward. However, this perception was challenged by Peter’s observation that a patient whom he would not describe as ‘good’ got to go home on pass. In order to resolve the dissonance he experienced, Peter then imagined that the staff were working to a different concept of good and bad:

*“What got me was, the good patients or the bad patients.  
Some bad patients, who’d do things like jump the fence to run to the nearest  
pub,  
they were the ones who were getting out [on Pass] at the weekend  
And I think, in my mind the staff were thinking,  
‘well, what’s he really done that bad?’”*

Peter, interview 1

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<sup>14</sup> Pass is given to patients when they are nearing discharge and facilitates a gradual move back home.

7.4.2b *Masking symptoms:* A further response to the feeling that they were being constantly observed by the nurses was for participants to mask how they felt:

*“I do know what caused the illness, and what, em  
it’s still there,  
the illness is still there  
you have to learn to surf it*

*You have to learn to surf the thoughts,  
and you don’t just walk away and it’s all gone  
This is something you learn to do in hospital.*

*You learn to keep,  
to internalise stuff  
which you don’t really want everybody to know you’re thinking.*

Me: right, so you begin to show what you, you filter what you show and what you don’t show then in terms of what you’re thinking

*Yes, yeah, and instead of being completely open and  
transparent, you then become  
more within yourself,*

*And, if you’re still having those thoughts, once you can,  
once you can remove the, em,*

*Once you can, once you don’t let on  
what’s going through your head all the time  
by either your body language or your  
what you say,  
Then you really are,  
you really have got it.”*

Becky, interview 1

Amanda described her ability to hide how she felt drawing on learned behaviour and internal resources:

*“I mean, if I’d walked past them for three days and never opened my mouth,  
they’d probably say, ‘Amanda’s on a downer’.  
But because of my personality,  
and my upbringing that I keep, you know,  
it’s rude to not, you’ve got to acknowledge people,  
no matter how you feel.*

*So I could always, ‘Morning.  
How are you today?’ you know.  
Oh, and feeling like shit.  
My head, dear God.”*

Amanda, interview 2

In the narrative excerpt above, Amanda implies the extent to which she perceived that the nurses' reports were based on their observations of patients' behaviour on the ward. Her narrative betrays her sense that she could mislead the staff by controlling how she presented, even when she felt very unwell.

Ewan was concerned about the negative impact that masking symptoms might have on the help he was offered, fearing that if he masked how he felt then he would be taken off his medication:

*"I mean there's no point ehh, people sort of saying, 'how're you getting on?' and you saying, 'yeah, I'm feeling great', they'll say, 'oh well, you're no needing any medication, or your level must be no bad, ken.'"*

Ewan, interview 1

The knowledge that they could mask how they felt to the extent that the nurses would be misled in their judgements regarding how well they were, led participants to worry about how they were represented in the nurses' reports to the psychiatrist and other members of the ward team.

#### *7.4.3 Can reports based on observation tell the whole story?*

The nurses were perceived as writing reports based solely on observation of behaviour, rather than interactions with the participants. The anxiety experienced by participants was created by their lack of opportunity to explain the cause of their behaviour. Thus, they felt they had no influence over how the nurses interpreted their observations, and therefore no control over how they were presented to the wider ward team.

Amanda addresses this issue in the following excerpt. She refers to the psychiatrist's decisions as being based on the "hearsay" of the nursing reports, implying that they were not based on discussions with her:

*"You were summonsed in [ward round] and there would be 4 or 5 other people there..."*

*And [the psychiatrist] never really asked you,  
I always felt he never delved in to how my mind was,  
or where it was, at that particular time.*

*It was all hearsay from the report, from the staff report*



*'cos they [the nurses] never asked,  
it was just a visual thing you know."*

Amanda, interview 2

Like Amanda, Jill's concern arises from the staff's lack of inquiry into how she felt:

*"I can remember on several occasions saying to my parents when they came to visit me,  
'you know, I would love to read their Kardex, because  
I don't know how anybody can write anything about me, because  
nobody's been near me.'*

*Because there's no way that anybody could know.  
I mean I would get up in the morning,  
I'd be really jittery, I'd feel sick, I'd be retching,  
and not a soul would know that.*

*Nobody ever asked me,  
nobody ever witnessed that."*

Jill, interview 1

Through their narratives participants made clear their perception that the nurses observed and reported their behaviours, and it was these reports that were the basis for clinical decision making by the psychiatrist. Participants therefore attached importance to these observations, managing their presentation on the ward in an attempt to influence the reports that the nurses made. The participants' perceptions that these reports were based solely on observation, because they were not given time to discuss how they felt with the nurses, resulted in anxiety about clinical decisions being based on incomplete information.

## **7.5 Us and Them: Tension between ward staff and patients**

### *7.5.1 Tension arising from frustration at the lack of help received*

Participants conveyed a feeling of tension between the ward staff and themselves. This tension seemed to arise from the gulf that participants experienced between their expectations of what the ward would offer them, and their experience of what the ward was offering. In particular, their narratives indicate that the common perception that the nurses were not interested in them, not listening to them, or showing empathy, led to feelings of frustration. Placed over these feelings of frustration was the feeling of powerlessness to change things on the ward.

In his first interview James explained how he experienced the development of an “*us and them attitude*” between the staff and the patients. He described an incident where his partner phoned the staff to enquire how he was. The nurse did not consult James’ notes, instead offering a response that James felt was a standard reply, not representing how he felt. At the end of this narrative he makes the following statement:

*“And so you, you begin to develop a,  
it’s alright now, in hindsight you sit and look back at it and you can understand  
that they were short staffed,  
but at the time it was more an us and them  
attitude developing with the staff.  
Things become quite eh,  
tense.”*

James, interview 1

In the above narrative excerpt James refers to a lack of staff as a possible reason for the nursing actions that he is criticising. James’ attempts to find logical explanations for the nurse’s behaviour belies a sense that he feels uncomfortable making such a criticism. Despite positioning himself in opposition to the staff by describing the situation as *them and us*, James seems to display some ambivalence toward the nurses. This ambivalence is evident in Amanda’s narrative below. Here, despite stating that she supports the nurses when the other patients are moaning, she also indicates that she too perceives them as lazy.

In the following excerpt from one of her narratives, Amanda tells how the tension between staff and patients develops, rooted in the patients’ perception that the staff are not doing anything for them. As the shift progresses, Amanda perceives that the tension between staff and patients increases, being relieved only by the change of shifts:

*“The patients’ gripe is,  
99% of the gripe from the patients is, the staff do nothing,  
the staff do bugger all  
and I, I can’t stand it when they do criticise the staff  
that is one thing that does make me angry*

*eh, yes of course I may think, ‘she’s a lazy waste of space’, but  
hey, over 365 days of the year*

*they do work  
they have responsibility  
I know what they've done for me  
So please don't criticise them*

*eh, but there's a lot of that aggro goes on, bloody this and that  
it is amazing that, this time round  
everybody gets a name*

Me: the staff get a name?

*Oh yes, absolutely, and that does amaze me  
It's pettiness you know, it's  
But you know there was an awful lot of that*

*Cos there can be quite a bit of aggression build up,  
and it starts manifesting itself in there  
and the dynamics can change so quickly  
on the patient side*

*Once or twice that's been quite scary for me,  
the power of that  
feeling  
in the smoke room*

*and I would start to feel threatened and then I'd think,  
'thank God, the nightshift that are coming on at 9, or 8.30pm.'*

Amanda, interview 1

Amanda's description of the other patients' complaint that the staff do nothing is incongruent with the many observations of the staff being too busy to talk (see 5.3.5). However, it may not be that they are literally doing nothing so much as not doing what the patients want them to be doing that is at issue here. When the nurses didn't act the way he wanted, James felt frustrated. He wanted to talk to them but they were always busy; he wanted them to listen when he told them what he needed, but they ignored his requests. James experienced these acts as intentional, leading him to perceive the staff attitude as confrontational:

*"I felt, I felt I was seen as a troublemaker.  
That's you know, over the food,  
over wanting to talk to them, you know,  
virtually anything, you know*

*I mean, certainly the confrontational attitude of staff creates tension between  
staff and patients."*

James, interview 2

### 7.5.2 Tension created when participants feel they are not believed

The feeling that they were not believed was an issue for several participants. Being believed is about one person validating another's experience by treating their story as a credible account of what happened. When a person's account is not believed, their experience is invalidated. Several participants referred to the concept that an account given by someone with professional status would be accorded greater credibility than that given by a person with a diagnosis of mental illness:

*"It's a professional, it's a professional, I don't know what it is,  
but they seem to, once you've been in a psychiatric,  
once you've been in an acute psychiatric unit your mind's gone anyway  
and they're on the other side of the table  
and their mind hasn't gone, so to speak."*

Jennie, interview 1

Robert expressed a similar view:

*"I mean society would tend to believe them [nurses and doctors] rather than me.  
I mean society would just tar you with the same brush as everybody else [all  
other mentally ill people]."*

Robert, interview 1

The power of health professionals to deny the experience of participants is exemplified by James when he narrates his attempts to discuss his diagnosis with them. He experienced their response as invalidating his experience of his symptoms, his diagnosis, and thus his need for help:

*"To me, it wasn't even so much as being fobbed off, it was them denying its [the  
diagnosis] existence again,  
because 'we know all about xxx syndrome,' the way it came across to me was,  
'well we don't believe in it. We've had other people in that said they've had xxx  
syndrome' and etc, etc. And  
to me, they were telling me, 'well, it's all in your mind.'"*

James, interview 2

Robert's narratives are littered with references to his sense that the ward staff did not believe him when he told them that he no longer heard voices, or experienced psychotic symptoms. Robert perceived that by interpreting his behaviour and accounts from within a mental illness framework, and interpreting improvement in his mental health in terms of the effectiveness of the medication, those representing the mental health system were able to keep him caught up in it:

*"I don't deny I had mental problems in the past,  
I've had a long haul with mental problems in the past.  
But people do get better.*

*But probably [name of psychiatrist] says, 'oh, but you probably don't hear  
voices any more because you are on the injection.'  
But I haven't heard voices for ages,  
not since the mid- nineties,  
the voices burned themselves out*

*He misinterprets things the way he wants to interpret them,  
and he gets believed because he's the so-called psychiatrist."*

Robert, interview 1

During an incident on the ward, Cathy stood up to two male patients who were bullying other patients in the smoke room. In the following excerpt Cathy makes clear that her actions are rooted in the wider discourse about bullying, and are not an illogical reaction caused by her mental health problems:

*"And I felt mine's [human rights] was threatened.  
It was just the fact of people with long term illnesses and things like that, that  
were courrying away.  
They just left the room.  
They just left the situation.*

*And I don't think I should have to do things like that [stand up to the bullies by  
myself].  
Eh, because I hate bullies,  
I hate people that do that*

*You see, I'm depressed because I've got depression  
I'm no daft.  
You know, a lot of people get that mixed up.  
And the only way to get rid of a bully, in my opinion,  
is to stand up to them."*

Cathy, interview 2

The experience that he wasn't believed because the staff "*couldn't trust me because I'm ill*" led Peter to describe how he felt he had to be able to prove the credibility of what he told the nurses:

*"That's one thing I had to learn to do,  
if I told the staff something, make sure it's backed up by some sort of evidence.  
Cos I think in the back of your mind you think you'll not be believed,  
like when they believed my sister rather than me."*

Peter, interview 1

### 7.5.3 *Participants' response to the experience of us and them*

During their interactions with the ward staff, the participants often experienced themselves in a less powerful position. Their narratives portray them as employing a number of strategies to exert themselves against the ward staff. One such strategy for “getting back” at the staff was narrated by James. He described how one of the nurses shouted at him in the dining room during the evening meal. One of his fellow patients, uninvited, came to his aid and defended him. James describes how the incident ended:

*“But anyway, my friend got up out of his seat,  
went along to the staff desk where the newspaper was*

*and it's actually the patients' newspaper anyway,  
but the staff grab it and sit at the desk and read it,  
especially the male staff*

*And they were sitting doing the crossword,  
so my friend actually cut out the crossword  
and cut all the crossword into little pieces.*

*And it was just a way, and it's, it is childish,  
but it, without resorting to something a lot more serious  
you know, it was about the only way that we could get back at them.*

*And that's what I'm saying,  
there was a real us and them attitude which I didn't expect.”*

James, interview 1

In his second interview James returned to the uninvited nature of the support he received from the other patient during this incident, using it as a means of countering the feeling that he was seen as a troublemaker by the staff. However, the feeling of support gained led him to believe that it was best to stick together on the ward:

*“And certainly, when the other people stuck up for me,  
at that point I hadn't encouraged them in any way to stick up for me.  
And it was only when they did that I thought, ‘well, we might as well  
sort of stick together, if, you know, if this is the way it's gonna be.’”*

James, interview 2

Peter described the manipulative strategies he employed so that he could get what he wanted from the nurses. In his narratives he describes in detail the lengths he went to, to ensure that the nurses perceived his actions as polite and respectful:

*“If you’re going to talk to a member of staff about wanting money out of the bank,  
and they say, ‘look, we’re busy,’  
assert yourself politely.  
If need be, mention patients’ rights,  
and the fact that the key must be available at all times in accordance to the  
laminated, eh [patients’ charter].  
Just mention that and they usually do things eventually.”*

Peter, interview 1

*“I thought, if a nurse has been narky at me, it’s like,  
defend yourself against her negativity.  
Turn it back and say something nice to her  
‘nurse I respect you’ve probably had a bad day,  
respectfully, please may I have the key  
I’ve got half an hour ‘til the shop shuts.  
Thank you very much for your effort.’*

*And if you make them feel appreciative of the help they’ve given you,  
plus you give them a compliment and realise, ‘wow,  
one guy’s been nice today, what’s he wanting? Money,  
I’ll get the key right now.’  
I found it does help if you do that, compared to what I’ve seen and witnessed  
myself,  
of patients being negative and aggressive.”*

Peter, interview 1

Participants described the development of tension between staff and patients based upon frustration related to their unfulfilled expectations. Participants experienced their accounts being discredited because of their mental illness labels, further promoting the sense that the staff were not on their side. The development of such oppositional feeling led to the development of resistance to the power of the nurses.

## **7.6 Summary**

The power that is the focus of this chapter is the power to influence the patient’s journey through the ward from admission to discharge. I began this chapter by setting forth the professional hierarchy as conceptualised and described by participants within their narratives. The professional to whom most power was attributed was the psychiatrist. He, or she, was perceived as the ultimate decision maker, and the person for whom all others worked.

The psychiatrist was perceived as having control over who was admitted and discharged from the ward. Participants' narratives indicate that they experienced the psychiatrist as occupying a gatekeeping role with regard to admission. With regard to discharge, there was a sense that participants felt they had little control and were resigned to wait until they were told they could go. However, whilst some might be waiting a while for such permission, for others the decision to discharge them was experienced as a surprise, leaving them feeling unprepared and rejected. Despite being admitted as a voluntary patient, participants expressed their understanding that they must still gain the psychiatrist's permission to be discharged.

The nurses were perceived as carrying out their work in order to support the psychiatrist's decision-making responsibilities. The observations and subsequent reports that they carried out in this role made them powerful, as it was their interpretations of the patients' behaviour that the psychiatrist's decisions were based upon.

The nurses' reports and interpretations were based on visual observations of participants' behaviour on the ward. Participants report that their awareness that they were being observed and reported on led them to modify their presentation on the ward. They perceived that the nurses would give more favourable reports for behaviours that complied with their concept of a good patient. Thus participants adapted their behaviour in line with what they thought constituted the behaviour of a good patient. A further modification of their behaviour was the masking of symptoms that some participants describe. Thus, despite feeling unwell, they presented themselves as coping. Participants were therefore anxious that, because they were constantly modifying their behaviour in order to achieve favourable reports, the picture that the nurses got about how their mental health was would be false. This was confounded by their experience that the nurses did not discuss with them how they were feeling, relying instead on their observations.

The experience that they were not getting the help they wanted led to tensions between the nurses and participants. Further tension was generated by participants' experience that their accounts were invalidated because they had a diagnosis of



mental illness. This left them feeling that they were powerless to influence the staff's interpretations because the staff were more likely to be believed than they were.

The experience that they had little power in comparison to the staff left participants with few options to try and exert some kind of influence over what happened to them on the ward. Again, as when participants described their actions to influence their self-presentation on the ward, the means by which they attempted to influence the nurses were manipulative.

## **7.7 Discussion**

The data presented in this chapter highlight participants' awareness of power relations in the acute ward setting. Observing relations between nurses and medical staff, allowed the participants to develop a picture of how the roles of each related. The significance of this process is seen as I present data pertaining to how the participants attempt to influence their passage through the acute ward.

Within the hierarchy of power relations on the ward, the psychiatrist was perceived as occupying the apex, with ultimate power over participants' passage through the acute ward. Participants' perceptions of the psychiatrist as occupying this powerful position reflect the development of psychiatric power through the medicalisation of misery (Pilgrim, 2005), and the consolidation of this through the statutory powers bestowed upon them by the Mental Health Act.

The experience that normal behavioural responses are interpreted as signs of mental illness is attributed to the psychiatrist's use of power to interpret and label behaviours from within a psychiatric framework. Such interpretations are influenced by the label of mental illness already applied to the participants, leading to the perception of behaviours as symptoms of illness. It is indeed the opinion of some authors that the process of psychiatric diagnosis is one of interpretation, premised on social judgement, influenced by the psychiatrist's beliefs, and other subjective data (Kendall, 1975; Pilgrim, 2005). Thus, through their powers to diagnose, and the influence of a label of mental illness on the interpretive process of diagnosis, the psychiatrist is able to interpret the participants' behaviour as symptomatic of illness.

Within the hierarchy of power relations on the acute ward, the nurses were perceived as occupying the stratum between patient and medical staff. As such, the perceived hierarchy replicates that which has existed since the days of the asylum (Porter, 2002; Busfield, 1986). In the asylums the attendants (later to be nurses) carried out the work prescribed by the psychiatrist (Buchanan-Barker & Barker, 2005; Porter, 2002; Pilgrim & Rogers, 1993). Despite moves to develop nursing as a profession in its own right, patients continue to perceive mental health nurses as the psychiatrist's agents.

However, the nurses are not perceived as powerless. The data present participants' perceptions of the nurses as powerful through their role in observing and reporting the patients' condition to the psychiatrist. Participants' narratives illuminate their perception that the nurses were constantly watching them, and noting these observations in reports for the medical staff. However, participants did not know the content of these reports, perceiving them as secretive. These perceptions of the nurses' role in relation to the patients and the psychiatrist resonate with Foucault's (1977) descriptions of panopticism.

Panopticism, as a means of creating discipline, operates by making individuals aware that they are always being watched, yet keeping the process of observation invisible to them. Through their awareness of this constant observation, individuals regulate their behaviour in line with the expectations of the regime within which they are caught up. Observation is ultimately of the powerful over the powerless; the prison governor over the prisoners, or the psychiatrist over the patients. Thus, the knowledge that the observer has the power to influence their situation - prolong a sentence or admission, or transfer to seclusion or secure ward – creates the desire to conform and in so doing, avoid punishment.

Within the ward, the panoptic mechanism operated through the participants' knowledge that they were being observed (ultimately by the psychiatrist through the nurses' reports). This resulted in them acting in a manner that they thought was consistent with the staff's concept of the good patient. By acting out the role of the good patient, the participants hoped to avoid the punishment of being sent to the

secure ward, or having their admission prolonged. They also perceived that they would be rewarded for being a good patient, by gaining pass to spend time at home.

Acting out the role of the good patient is cited by a number of authors as a means of surviving the acute ward (Everett, 2000; Goffman, 1961; Chamberlin, 1999). As Chamberlin (1999: 175) describes (emphasis in the original):

*“The survival skill called ‘playing the game’ was another thing I learned from the patients around me. Playing the game meant learning how to give the **appearance** of being a ‘good’ patient. It meant ‘co-operating’ with treatment, ‘volunteering’ to make beds and mop floors and wash dishes, expressing appreciation for the ‘help’ and ‘support’ of the hospital ... Since I had been told that schizophrenics couldn’t control their behaviour, the staff apparently believed it was impossible for me to be acting purposefully toward my goal of freedom.”*

As Chamberlin (1999) indicates above, her perception is that the staff do not believe that she would have enough self control to be able to choose how to present herself within the ward. This throws up the conflict highlighted by some participants; they wanted to influence their self-presentation in order to hasten their progress through the ward, however, they were fearful that such presentations would result in any support they were receiving being withdrawn because they were judged not to require it.

The answer to this conundrum perhaps lies in an exploration of the power inherent in the panoptic mechanism. Panopticism is powerful through its distancing of the observer from the observed. Thus, nursing observations have been described as a means of nurses distancing themselves from patients (Bray, 1999; Fletcher, 1999; Dodds & Bowles, 2001). This distancing creates a sense of powerlessness in the observed who are unable to influence the interpretive process of the observer. The only means available to the observed for purposes of influencing reports is through their self-presentation; that is, through behavioural means. Thus, by placing observation in a central position within nursing practice on the ward, what is observed is what the patient chooses to present, rather than what he or she is truly feeling. This negates the knowledge acquisition purpose (Foucault, 1977) of observation, making it a questionable basis upon which to base interventions.

Freedom from such power relations comes from reducing the distance between observer and observed, such that the observed feel that they have some power within that relationship; power to influence the observers' interpretations of what they see, and subsequently to influence their presentation to the person at the top of the hierarchy. In mental health nursing, this distance is diminished by the development of relationships with patients in which they feel valued, respected and cared for. Relationships where there is a level of trust that allows patients to discuss how they feel, and where the professionals with whom they interact are interested in understanding their situation. Thus Buchanan-Barker and Barker (2005) introduce the concept of bridging as a metaphor to denote the need to reach out to, rather than distance ourselves from, patients on the ward. Dodds and Bowles (2001) also discuss the need to refocus nursing away from observation toward development of relationships with patients. The results of their project indicate that it is possible, through the development of positive relationships with patients, to keep patients safe.

It is the distance between nurses and patients that created the tension referred to as *us and them*. This tension arose through participants' experiences that they were not believed, not listened to, and not getting the help they were asking for. The lack of interaction created by, and through, this distance between nurse and patient led to frustration and disappointment. This was found to be an aspect of the detrimental relationships that Coatsworth-Puspoky *et al.*, (2006) identified (see section 5.6). Thus once more, it can be anticipated that the formation of positive, respectful nurse-patient relationships, in which patients feel that they are valued and their experience is validated, would diminish this sense of opposition.

## **8 Holistic Re-Presentations Of Participants' Narratives In Poetic Form**

### **8.1 Introduction**

In this chapter I present a collection of poems inspired by the analysis of the participants' narratives. These poems are representations; they represent my interpretation of the central message of each participant's narratives about their experience of being a patient on the acute ward. The poems are a holistic representation of the participants' narratives, presenting not only what was told but also the viewpoint and manner of that telling. As such, the poems offer the reader a sense of how the material drawn out in the thematic presentations of Chapters Five to Seven is bound together in the narratives of each participant.

Poems are not instructive, they do not detail facts; rather, they offer a window through which we are invited to look. They allow the reader to engage with the subject in their own way. For this reason, the poems are presented without introductions or detail of my interpretations.

## 8.2 *Robert's story*

He recalled me to the ward  
Policing me, exerting his power  
    through the mental health system,  
    through my CTO<sup>15</sup>;  
Making me feel like a prisoner in an open prison

I'd had a row with my social worker.  
She told the consultant.  
He interpreted it as signs of illness,  
    but I wasn't ill, I was angry;  
A normal emotional reaction.

I used to be ill; I don't deny it  
Heard voices and experienced delusions.  
But that is my history, not my present situation.  
Nobody believes me,  
    They won't let me experience recovery.

And I try to talk to the nurses,  
    about what I'm experiencing now.  
They don't say anything, keep quiet,  
    their notes maintaining the consultant's view  
    that I'm a paranoid schizophrenic.

I see that some of them believe me,  
    but they can't say anything to me  
    because they must support the consultant's view.  
And who does society believe?  
Them, not me.

And I feel hurt and frustrated  
    that no-one believes my point of view.  
Expressing my anger, sometimes I shout.  
But nobody asks what the shouting's about,  
    noting it down as aggressive and verbally abusive behaviour.

Some of the staff on the ward are good,  
    whilst some display indifference  
    to patients who need them and want to talk.  
They would rather talk amongst themselves  
    than talking to the patients.

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<sup>15</sup> A Compulsory Treatment Order which is applied as a section of the Mental Health and Treatment (Scotland)(2003) Act

You have to fight for time with them,  
and even when you succeed  
you feel you don't have their full attention.  
Turning again to talk to colleagues, cutting you off  
like they're always trying to get away from you.

And they don't talk to you like they do their colleagues  
about everyday things.  
They have a 'patient' way of talking,  
As if we are not engaged with the everyday world  
because we are mentally ill.

The days drag on monotonously,  
long pregnant pauses punctuated by meals and cups of tea.  
No stimulus or OT<sup>16</sup>.  
I always take things in with me  
to help me eek out the day.

I take myself off into my dreamworld of creativity,  
immerse myself in my art.  
Detached from the present,  
Giving myself space away from this place,  
My way of breaking the monotony.

You strike up a camaraderie with other patients,  
With some you develop close friendships  
confined to your time on the ward;  
Brief interludes in your life,  
offering a release from the boredom.

And everything I've told you is the truth,  
I am an honest person;  
I come from an honest family;  
I have watched intently so that what I say is believable,  
despite my label of mental illness.

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<sup>16</sup> Occupational Therapy

### 8.3 *Jennie's story*

I don't believe in psychiatry.  
80% of the drugs are toxins;  
20% are sedation;  
And ECT is just electrocution.  
What people need are food, time,  
and a bit of sedation.

Ward routine revolves round medication and meals.  
There's eight o'clock medicines;  
There's one o'clock medicines;  
There's six o'clock medicines;  
There's ten o'clock medicines,  
so there's no time for the nurses to get to know the patients.

The day-staff medicate the ward then,  
Serve up breakfast;  
Serve up morning tea;  
Serve up lunch;  
Serve up afternoon tea and then supper,  
so there's no time to develop relations with the patients.

The main job of the night staff  
is to ensure that the patients have not all escaped.  
Shining their torches in the middle of the night  
into your dorm as you sleep,  
Waking you from your dreams,  
checking you're still there.

The nurses are trapped in the system,  
trapped in the ward routines,  
no time to spend with patients.  
Burnt out and exhausted,  
unable to take on the patients' problems,  
Just getting through the day.

So patients turn to their peers for support.  
People just came to me, wanted to talk,  
I must be quite approachable.  
I ended up talking them through their problems,  
taking on their burdens,  
Exhausted by 24 hours on the ward.



Many patients are trapped in the system  
becoming frustrated and violent,  
Violence turned towards staff or in on themselves.  
Patients who are violent should be removed  
and placed on the secure ward,  
Not allowed to run amock,  
throwing chairs whilst the nurses monitor them.

And you feel vulnerable in the dormitory  
not knowing who's next to you,  
or who will go through your stuff.

No privacy;  
No security;  
Nothing's safe.

I don't believe in psychiatry.  
Most of the patients are victims of their socio-economic situations,  
misplaced persons,  
But you don't get to know that unless you are a patient.  
The staff are flaked out,  
There's too much going on  
for them to discover what's wrong with their patients.

#### 8.4 *Becky's story*

This admission to the acute ward was not my first,  
But it was the longest;  
I have spent long times in hospital in the past.

What stands out the most?  
A growing sensation,  
An incredible feeling that you had absolutely no privacy,  
that you were being observed 24/7,  
there was nothing you could do that wasn't noticed.  
That might have been part of my illness.

So you do what's expected of you,  
do everything by the book,  
Don't let any chink appear in your armour.  
If you do it by the book they can't get at you,  
nothing can hurt you.

The illness never leaves.  
In hospital you learn to surf the thoughts,  
to internalise stuff,  
Not give away what's going through your head,  
stop being transparent.

When you felt threatened by something the staff said,  
you took it on the chin,  
didn't react.  
Mustn't let them see you're bothered!  
It's very difficult to do.

There was a man,  
(who was probably just being a man),  
made an aggressive and rude comment to me.  
The nurse looked at me – I was going to react  
Her look said, "don't react",  
I didn't ,  
but it all went inside.  
She knew the risk of violence if I stood up for my rights.

I looked into the charge nurse's eyes that night and I knew,  
I knew she could see my pain.

Another thing,  
I made it clear to a female patient that I wouldn't stand for her nonsense.  
She threatened me with violence when I got out,  
    I was a victim.  
I returned from overnight pass,  
She had been moved to my dormitory,  
    I wanted to turn round and leave;  
My motivation to be discharged increased.

Something else too,  
When you're first on the ward  
    you make friends with people round about you,  
You might be bosom buddies for two weeks, but then,  
    they get better,  
    leave,  
    you're never going to see them again.  
You're left in a limbo;  
    the making friends mechanism shuts down.

The people in there were quite violent,  
    not my sort of people.  
I avoided being with them,  
Hung around the nurses,  
Avoided places like the smoky.

When you start going out  
    you just want to get in amongst your own people,  
    be with your own friends;  
Friendships that you have,  
    that you've known, or  
    friendships that you can work on.  
The making friends mechanism shuts down.

I'll tell you something else,  
I overcame something this time:  
    my fear of long term psychiatric patients,  
    and becoming one of them.  
Over the weeks and months  
    I got to know some of them by name;  
Began to see them as just people like myself.

What I had not realised, was they wanted me to get better,  
    they wanted me to get out of hospital.  
They wished me well when I was discharged;  
    they were all on my side.

### 8.5 *Peter's story*

I knew I was ill,  
Kept going to the doctor,  
    asking for referral to hospital;  
I wasn't ill enough she said.

I could feel my illness taking hold,  
Losing my sense of what was real,  
    feeling threatened;  
I needed to get into hospital.

I had a plan to get me in,  
    vandalise some property.  
Somebody will phone the police,  
    they will take me to hospital.

I've finally made it to hospital,  
Now I'm safe.

The nurses make their observations,  
    Judging you as a person,  
Write these on your record for the consultant,  
    so he can make his decisions.

So always make them feel that they're in charge,  
    even though they're getting their orders from above.

If you are nice to the nurses, they will be nice to you.  
You need to treat them with respect,  
    be a good patient,  
Because it all goes on your record.

And don't walk round all scruffy,  
    unwashed and unshaven,  
That shows a bad attitude;  
It will probably go in your record

Make the staff aware that you are trying to help yourself,  
    let them know you want to get out.  
Don't be lying on your bed, or smoking all day,  
    because it won't look good on your record

If you knock on the door, and the staff are busy,  
    let them know where you will be.  
Don't disappear off, it'll only annoy them,  
    and that won't look good on your record.

And when you are aware that the nurses observe you,  
it's hard to be yourself.  
I hid my sense of humour;  
Didn't want it to go on my record.

When you're on the ward you are a 'mentally ill' patient,  
with no credibility as a competent agent,  
Always feeling that you need evidence  
to back up what you say.

But when you get out,  
get your discharge papers,  
Then you can become, once more,  
a fully paid up member of society.

### 8.6 *John's story*

I was only in a short time,  
the doctor said he'd not keep me long,  
Not like the last time, when  
the admission went on and on.

It's the doctor who decides, you see,  
if you are getting out,  
That's why you should be polite to him,  
never scream and shout.

Because if you lose your temper,  
or challenge what he says,  
He will make your time more awkward,  
or extend how long you stay.

They say they can leave any time,  
that simply isn't true,  
If staff think you're not ready,  
they will section you.

But there's some who're on a section,  
who take full advantage of the fact,  
They can't be put out for substance use,  
while under the Mental Health Act.

The inmates sit around smoking,  
there's little else to do,  
Telling nonsense stories  
that can't possibly be true.

And their stories irritated me,  
but once I felt safe enough,  
Instead of getting cross at them,  
I knew that I could laugh.

The boredom leads to arguments,  
at mealtimes in particular.  
Intimidated, leaving your meal on the table,  
you retreat to somewhere safer.

And if one of them hits the other,  
they're straight down on the floor,  
The nurses restrain them, move them up  
to the ward where they lock the door.

And when you speak to the nurses,  
    they ask you silly questions  
Like, “what was the celtic score last week?”  
    and “what did you have for breakfast?”

And I know that they’re just testing my brain,  
    testing the state of my memory,  
So I answer them with sarcasm,  
    because they know the answers already.

I never want to go back in,  
    I can’t stand all the nonsense  
Of the other patients’ stories, and  
    the nurses’ silly questions.

8.7 *Amanda's story*

I had to be bribed,  
I conjured up this horrendous image,  
    there was no way I was going into a mental asylum.

*Ghastly.*

I was delivered to the acute ward;  
I was like a puppy dog,  
    I mean, I was just shaking.

*Petrified.*

I was put into a single room;  
I was searched,  
    no reason for being searched, given.  
Everything was recorded,  
She was very officious,  
    I just didn't open my mouth.

*Hellish.*

I just sat in this room,  
    Waiting.  
I was taken along for lunch;  
All mental patients,  
    Queuing.

*Hellish.*

Bed time,  
    thank goodness they didn't lock the door.  
Patient next door on 24-hour watch,  
    looked a criminal almost.

There's a little curtain on the door  
    "you must have it half open!"  
Now I know it was observation,  
    but I wasn't aware of that then.

*The first 24 hours was hell.*

As the days went on,  
    it wasn't as bad as I thought.  
The patients were kind,  
    that's what cracked it.



I was put in a dorm,  
    wasn't allowed out of the building for 48 hours;  
That wasn't explained to me.

I was given the booklet with my assigned nurses;  
That wasn't explained very well  
My senior nurse was the one that administered me,  
    she was horrendous,  
    my whole world collapsed.  
Y was also my senior nurse,  
    she was on holiday or sick leave,  
I never saw her.

*Nobody, I saw.*

Nobody explained to me the regime,  
    what I should expect.  
Nobody informs you that you will definitely be seeing your psychiatrist,  
    you have to hang about and wait.

It's expected of you to approach your named nurse,  
    I don't want to be a bother,  
I'll wait to tomorrow;  
Tomorrow comes,  
    that person you want to speak to is off.

I wasn't pushed along enough,  
    a lot of it's down to yourself,  
I worked hard to get out of there,  
    because I saw the revolving door.

*And it's not going to happen to me.*

I managed myself the best I could,  
I used all the occupational therapy;  
I walked every night with a fellow patient,  
    I did it for him as well as myself.

I went to the gym,  
Back with the benefits to the other patients,  
    Revving them up,  
“Why don't you come to the gym?”

*I was quite a mentor.*

I was just a closed book,  
    they had to haul me in,  
Started pressing a few buttons,  
    bit of release, bit of release, bit of release.

It was now down to me;  
    nobody can do this bar yourself,  
A rocky road,  
    hard work.

Discharge,  
A light had been switched on;  
    I was coping,  
I'd come a long way.

Patients' gripe: the staff do nothing,  
    I can't stand it when they criticise the staff,  
I may think, "she's a lazy, waste of space",  
But over 365 days of the year  
    they do work;  
    they do have responsibility,  
I know what they've done for me.

The dynamics can change so quickly,  
    That's been quite scary for me,  
The power of that feeling in the smoke room,  
    I would feel this build-up;  
    I would start to feel threatened;  
    I was glad there was a male on,  
Security for me,  
    My safety.

And you wonder how many people feel like that,  
    that's the first time I've spoken about this,  
    that I felt it.

## 8.8 *James' story*

### **I**

They said, "come and speak to us";  
if you went they were always too busy.

It was in the news,  
People with problems like mine,  
killing themselves and other people.  
Is this what will happen to me?  
I live with fear that this is my fate.

I tried to speak to them about that,  
But they were too busy.

### **II**

Is it because they are short staffed,  
they don't feel they've got the time?

My partner phoned,  
"he had a full night's sleep,"  
A standard reply, didn't check my notes;  
"you know I was up most of the night"

I think it's because they are short staffed,  
they don't feel they have the time to check.

### **III**

If a patient says that they're in pain,  
they must do something about it.

My skin condition flared up;  
"It's not life and death, the doctor'll come when he comes."  
It took 12 hours for a doctor to come  
and sign a prescription for E45 cream.

All the time I was in pain,  
I was quite miffed at that.

### **IV**

You begin to develop an Us and Them attitude,  
things become quite tense

They cut my sleeping tablets down  
said I was sleeping fine.  
Exhausted, my arguments fall on deaf ears.  
One night they capitulate, I sleep,  
that was to be for one night only.

Why were they playing such games?  
Were they really just trying to annoy me?

**V**

Male nurses growled and intimidated;  
testosterone fuelled tension.

Images of guards, as they rush to incidents  
in other parts of the hospital,  
Heighten the tension,  
making us vulnerable.

One male nurse went nuts at me,  
My friend stood up to them,  
Chopped the crossword staff were doing,  
into little pieces.

It was our only way to get revenge,  
in a situation of Us and Them.

**VI**

In the smoke room  
we counselled each other.

4 or 5 of us understood,  
that we weren't getting much help.  
Our best bet was to support each other,  
bringing us in close.

So it was quite upsetting  
when our friend took his life.

**VII**

I grew very frustrated;  
set off toward the railway line.

I had reached a low point;  
I had put myself into a mental institution expecting help;  
I wasn't getting much help;  
I was beginning to feel worse.

Hospitals are meant to make you feel better,  
to feel worse seems rather perverse.

## VIII

Discharged;

“There’s nothing we can do for you.”

It was a huge disappointment.

My relief at being allowed in voluntarily;

My hopes that it would make me better,  
lie broken, replaced by fear.

When will it all build up again?

I don’t know how much more I can take.

8.9 *Cathy's story*

I've had experience before, of being on acute wards  
in other hospitals.

This was an inviting place,  
it made you feel at ease.

You had to wait for the doctor to come,  
I understood that from being in other hospitals.  
Some of the people that came in for the first time, didn't understand,  
they became very impatient.

I thought the nursing staff were fine,  
I thought they did their job well,  
I thought, like on previous occasions,  
they have a terrible amount of paperwork.

The method of dispensing medication was the same:  
queue up outside a room.  
I had to get a lot of medication, so I took it in a big handful,  
some people have to pick it out one pill at a time.

And the place was scrupulously clean.

I don't like bothering senior staff for a menial task  
but I couldn't tell who anyone was,  
cos they wear badges on the waist band  
But I cannae bend down that far to see,  
it's one of the only criticisms I have.

I felt the food was very good.

Two boys went missing from the ward,  
Allowed back in that night,  
drunk,  
playing loud music in the day room.

And it transpires a female patient had done a similar thing,  
but caused no problem,  
And she was put out.

Everybody left the room bar me,  
I wouldn't be intimidated,  
I hate bullies.  
So I got into an argument with them.

I certainly felt intimidated,  
I wanted to leave the ward  
That's the only complaint I've got,  
it was bad judgement of the staff.

Again, I know the system:  
If they're under a section, you cannae put them out the ward,  
but they certainly have facilities they can put them into up there.

There should be a patients' charter on the wall  
to protect everyone's human rights.  
I should have the right as a patient to feel safe,  
protected against people like that coming in.

I have nothing to complain about,  
It was spotlessly clean.

Inside the goldfish bowl,  
you watch the world go by outside,  
The time the postman comes;  
The time the pharmacy van delivers;  
The dinner van arrives - it's lunch,  
Punctuating the day's routine.

I thought they'd have taken you for walks,  
taken us out as a group.  
I suppose they might be frightened you run away.

The days run into one another,  
connection with the outside lost.  
As you get better you say, "I wonder how many letters I've got?"  
Missing friends,  
Missing the Bingo,  
Beginning to reconnect with my life out there.

But no, I cannae complain, honestly,  
there was no sister kratchet,  
she wasnae there.

The staff were available  
but they were always writing up files.  
I don't think any of them are work shy,  
other than staying in the office.

Obviously, when they're doing a synopsis of what I've said,  
multiply it by 30,  
It takes a lot of time.

A wee girl came in and had shock treatment;  
I could tell she was getting the shock treatment, I knew,  
but probably everybody else on the ward didnae notice;  
that thing in the back of her hand.

There's quite a camaraderie with the other patients,  
those with similar illness congregate,  
But there's always one that advises the wee ones that 's coming in,  
"I'll tell you what to do to get ..."  
But it's interfering with people's medication;  
I've noticed this in the other hospitals too.

I put off going into hospital,  
"I cannae put up with the shouting and bawling that goes on"  
The disturbance created by a wee core of patients;  
I've seen it in other hospitals too

I don't think there was anything they could have done,  
To make you feel more comfortable.



8.10 *Jill's story*

Shocked:  
“Hello, I’m your admitting doctor”  
Somebody’s conned me,  
I thought I was just going to be assessed;  
“You don’t have to stay if you don’t want to.”

Desperate,  
I agreed to stay.  
If I went home, and the next day I had to phone my GP,  
And he’d set all this up for me,  
That wouldn’t be very fair.

Tearful:  
“We’ll give you some lorazepam to settle you down”  
Fell asleep.  
Woken hours later;  
“We forgot about you.”

Frightened,  
I didn’t know the ward routine  
Or where anything was.  
Nothing explained,  
Not shown around the ward.

Neglected,  
I lay on my bed and cried.  
Nobody came.  
I felt conned,  
Neglected.

Expected  
People would be helping me,  
Counselling me.  
Nobody came near me,  
I just lay on my bed and cried.

Frightened,  
I didn’t know who I was in with,  
Or how to react to the other patients;  
Do I look at them?  
Better not ignore them.

Crying,  
I lay behind the screens  
Waiting for someone, but  
Nobody came.  
I didn’t even know their names.

Antisocial?  
“We don’t do antisocial, you have to come find us”  
How could I when I’d been ignored, and  
Nobody introduced themselves?  
I couldn’t approach them.

*I can’t stay here, they’re doing nothing for me*

Empathy,  
One nurse came, and confided in me  
That she could see I was struggling.  
Relieved to have someone recognise my plight,  
And acknowledge my feelings.

Busy;  
What do the nurses do?  
We were all self caring,  
Showered, dressed and fed ourselves;  
So why did they not have time for us?

Friends;  
A patient took me under her wing,  
Introduced me to a couple of others.  
Chatting and eating together,  
My saving grace.

Vulnerable,  
My friends were on pass for the day,  
I was stalked by a female patient.  
Eating my lunch, she moved to my table,  
Missing my face as her fist shot toward me.

Hysterical,  
I retreated to the safety of my room.  
The staff said they were watching,  
Would keep an eye,  
But I had to understand she was ill.

*I can’t stay in this place any longer*

Institutionalised,  
Queuing for medication,  
Determined I was not going to do that.  
I didn’t want to be difficult,  
So I joined the queue.

Escape,  
The CPN said I'd been discharged  
Earlier than he would expect.  
I had planned my discharge,  
And suggested a support package

*Because I couldn't stay there any longer*

Angry,  
I feel really cheated,  
Told that I would get help.  
That's why I agreed to stay,  
But all it was, was time out.

Stigma.  
Now it's in my medical notes,  
That I've been in a psychiatric hospital.  
I could deal with that, if I thought they had helped,  
But my expectation was not fulfilled.

8.11 *Joanne's story*

What's the point in being here,  
if you're left to your own devices?  
Pottering about all day.

I expected they would give you counselling,  
Support,  
Teach you coping strategies.

But they didn't come and speak to you,  
You had to go to them;  
I worried that they were too busy to speak.

So I wrote how I felt in letters,  
Hoping the staff would then approach me,  
And talk about how I was feeling.

They gave the letters to the doctor,  
But I never heard anything back;  
So that was a waste of time.

They said they would give me a relaxation CD,  
And a letter from the doctor;  
False promises, I didn't get either.

I was left pottering about the ward all day,  
Wondering why I was there;  
Nothing to do, no plans for my care.

I had thought I was going in for a few days,  
But the psychiatrist suggested I stay;  
In the end I was there for two weeks.

And I don't know why they kept me in,  
The peace and quiet was good;  
But I still don't feel any better.

And I talked with the staff about leaving,  
They said that I wasn't ready  
So I stayed; I was in voluntarily.

Then they gave me a day pass, to see how I would cope.  
I went AWOL for the weekend,  
They marked it down as 'weekend pass.'

Going AWOL was a sign that I wasn't coping,  
But they never asked why I ran off,  
Just discharged me.

What was the point in being there?  
Left to my own devices.  
I needed help.

8.12 *Josie's story*

It's no' so much being the patient,  
I'm still a bit old fashioned,  
It's the stigma that's still connected, when you say you've been in hospital;  
The reaction of people, when they know you've been in a mental institution.  
How should my absence be explained,  
when people ask, "where have you been?"

I felt like a guinea pig trying different medications,  
a Zombie all doped up.  
They didnae work.  
They tried me on a new medication,  
hoping this would work.  
It didnae work.

The nurses lost interest in me;  
'What kind of problems is she,  
that can't be helped with medication?"  
"Is it my fault?"  
I began to worry,  
"What is so wrong with me that nothing works?"

"Let's try ECT,"  
they said it was different from years ago,  
I knew people whose minds it had scrambled.  
I had no mind left to be scrambled,  
so I agreed as a last resort.  
It didnae help.

The psychiatrist scolds that I won't get better, if I don't talk to the nurses.  
They never come talk to me,  
and they always seemed too busy.  
So it all bottles up,  
then I 'crack up,'  
They have to come talk to me then.

There was one person I could talk to,  
a doctor on the ward.  
He listened, and gave me time,  
treated me like an individual.  
If it hadn't been for him,  
I don't know what state I'd be in

And the passing of time escaped me, as I lived from day to day,  
Sitting in the present,  
not able to see the future,  
My concentration gone.  
Flicking through magazines  
waiting for 2 o'clock, my husband's visit.

Worrying,  
Who will I be when I come out?  
What kind of state will I be in?  
Will my husband be able to cope?  
After all, not everybody can cope with someone  
    who's been in a mental institution.

And all that time I was in there,  
    trying different tablets and ECT,  
It didnae work.  
So the pharmacist looked back, and now I'm on  
    a tablet I was on years ago.  
And I just came out the same way I went in.

### 8.13 *Ewan's story*

I realised myself that there was something up;  
My level was off.  
Twice before I've tried to finish it,  
But this time I took control;  
Got to the doctor's.  
Cos when your level goes off, you just havnae got any control.

The doctor said, "we'll try and get you into hospital."  
I've been in before, so that was ok,  
They work miracles in there you know.

You got no medication for the first three days,  
No help when you couldn't sleep.  
They're observing, to see how you react,  
So you mustn't close your eyes,  
Feign sleep,  
When they come round with their torches.

You're allowed outside after the first three days,  
They sort of give you the trust.  
With nothing to stop you going off to England,  
But the knowledge you're breaking that trust.  
They watch you 24/7,  
To see how you react.

People jump the fence,  
I ran away.  
Running, and running so free.  
You stop, ask yourself what you're going to do,  
You've no money or anything.

I went back and the police were there.  
I wouldn't go into the ward,  
Scared that I would be punished,  
Ashamed of having run away.  
The nurse was nice, said it was fight or flight.

I ran, and I thought it would be better;  
But how long is it better for?  
2 minutes? 3 minutes?  
It doesn't solve anything.

You've got to understand within yourself,  
If you go into the ward, you have to stay until you're sorted.  
There's no point in being a renegade,  
Smashing things up,  
Getting moved to the locked ward;  
I was scared I might end up there too



There's no point in saying you're fine if you're not,  
Cos they won't be able to help you,  
And they will move you out of the ward,  
If they don't think you're making an effort;  
You have to show that you're trying to help yourself.

They reward you with a 'pass' for getting stuck in,  
For working hard;  
You've reached a point where you're ready to go out,  
Another step closer to discharge.

Still it's hard seeing others getting pass,  
And you're stuck on the ward.  
You tell yourself, they've been there longer,  
They're further along the continuum.

And it's like a scale, when you reach a certain point  
it's time for you to go.  
I got a couple of overnight passes,  
Then they said I could go home;  
I don't want to go *now*;  
All the back up's there, like my sort of safety valve.

There was a sort of tension.  
I felt safe in the unit,  
But when there, I wanted to be out,  
And when out, I wanted to be back;  
My safety valve

Subtly, they gather information,  
Informally through conversation.  
Noting your replies,  
In a dossier about you.  
Meeting to decide how long they'll keep you.

The nurses said to come and speak,  
That was mostly fine.  
Sometimes they said they were busy,  
But there didn't seem to be much doing;  
No admission coming in,  
Nobody kicking off,  
I should have been able to speak.

Most of the staff were good, you could have a laugh,  
Develop a relationship.  
Once I got to speak to my senior nurse she was good,  
Helped me sort things out.

It's a good place to get you sorted,  
Get you're level right.

#### 8.14 *Connor's story*

That's twice I've been in the acute ward.  
The first time was the same as the last;  
    You're awfy well looked after,  
    The nurses are always there if you want support,  
I cannae really fault the staff.

The meals are excellent.  
The smoking room's excellent.

But the youngsters have an attitude problem,  
    Treat the staff terrible:  
Flick ash on the floor.  
I had to speak to them, tell them  
    "You cannae do that."  
Asked for the Hoover,  
    Cleaned up the mess.

They don't know how cosy they've got it;  
You're really well looked after,  
    I cannae fault the staff for anything when I was there.

We chatted in the smoke room,  
    This was my therapy.  
Talking about things like I can't talk to my friends,  
    Common experiences,  
People with the same problems;  
It was the best therapy I've ever had.

The best atmosphere was in the smoke room,  
The nurses don't come in.

A couple of patients were violent,  
    One skelped a male nurse.  
I heard the smack,  
Went over,  
The nurse had him down,  
    I held his legs.  
His personal alarm wasn't working.

Later the nurse came and thanked me,  
Asked if I was ok.

Five nurses ran past the smoke room,  
    “Help,”  
Being chased by one of the patients.  
That’s no right,  
That’s five lassies,  
    Who’s here for to help them?  
There was no protection for them at all.

I calmed him down,  
    Took him back to the dining room.  
I dread to think what would have happened if he’d got hold of one of they women;  
The staff had no protection, no protection whatsoever.

And that must affect the in-patients;  
    To see somebody getting slapped one day,  
Somebody getting chased the next.

And I thought, “if he’s going to be doing that  
    He really shouldn’t be in here.”  
There’s a locked ward,  
    But he’s ill, and doesn’t know what he’s doing.

A young boy hit one of the male nurses,  
    I seen it coming for a couple of days.  
He got sent to the locked ward;  
His attitude was all wrong.

I felt very secure in there,  
    Nobody could get at me;  
Found security in the daily routine.  
I had a sore stomach,  
The nurse got the doctor,  
    Sorted it out;  
The least wee thing and they’ll sort it out.

I felt very secure in there;  
I feel very un-secure out here.

## 9 Conclusions

### 9.1 Introduction

This thesis is an account of a qualitative study of individuals' experiences as patients on an acute psychiatric inpatient ward in Scotland. The study aimed to understand individuals' experiences through an analysis of their narratives about being on the acute ward. An unstructured interview approach was used to allow participants to develop their narratives in the way that they felt best represented their experience. The data were rich, representing an array of individual experiences. Uniting these individual accounts were elements that were identifiable as shared experience; aspects of the experience of being a patient on the acute ward that featured in the accounts of many of the participants.

The research was placed in context in Chapter Two of this thesis, with an examination of literature pertaining to acute care, and Scottish mental health policy. My review of mental health policy literature placed acute care in context within the wider provision of mental health services, and focused on particular conflicts between political intent and the translation of this, through policy, onto the ground. The acute care literature highlighted the state of current knowledge, and the gaps in the literature. In this chapter I will reflect on how this study has contributed to the field of knowledge about acute psychiatric inpatient care.

The theoretical concepts underpinning the choice of methods and research design were discussed in Chapters Three and Four. The analytic approach was based upon ideas developed by Gee in the field of socio-linguistics. Although Gee's work has been utilised in research by others (cf Riessman, 1993; Kendall & Murray, 2005), I found no evidence of its previous use in mental health nursing research. The impact of conducting research based upon these principles, and other methodological issues are discussed in this chapter.

As discussed above, the data gathered in this study offered a broad picture of participants' experiences of being a patient on the acute ward. In the next section I will summarise the key features of the participants' experiences as presented in

Chapters Five to Seven. I will then draw out the elements that cross the boundaries of each of the thematic chapters, uniting the participants' experiences.

## **9.2 What is the experience of being a patient on the acute psychiatric inpatient ward?**

### *9.2.1 Introduction*

The data portray the participants as constantly trying to make sense of what was happening in the environment whilst on the acute ward. During this sense-making activity the participants drew on particular discourses, as the resources available to them, to enable them to understand their environment and verbalise these understandings in narrative form. It was from these discourses that participants' expectations pertaining to their admission to the acute ward were derived. Thus, participants judged their experience against the expectations created by the application of discourses to their situation.

Participants drew upon discourses of help, safety and power in order to make sense of their experiences. Data drawing on each of these discourses was presented in chapters Five to Seven. In this chapter I will re-capitulate the participants' experiences as presented in the data chapters under the headings of help, safety and power.

Emerging from within these thematic chapters there are three strands that unite the participants' experiences: the dissonance between expectations and experience; the search for, and perceived importance of, the nurse-patient relationship; and patients as strategists. In sections 9.2.5 to 9.2.7 I draw out these three strands as I present my conclusions about the participants' experiences.

### *9.2.2 Help*

The data from the interviews provided a clear picture of participants' expectations of the help they would receive when on the acute ward, and of the help they actually received. This picture highlights the dissonance between participants' expectations, and their actual experience, of getting help on the acute ward. This dissonance resulted in feelings of frustration, anger and disappointment.

The help most expected by participants was that the nurses would spend time talking with them. Further, they expected that the nurses would initiate these contacts, seeking out the participants to talk to them, or approaching them if it was clear that the participant was in need of support. However, on the ward, the participants found that they were required to approach the nurses if they felt they needed to talk. This was not what they had expected, and resulted in them feeling that the nurses were not interested in them, or did not care about them.

The feeling that the nurses were not interested in them was compounded by the participants' attempts to speak with the nurses being rejected when they were told that the nurses were too busy. Their observations that the nurses were often involved in administrative or ward management tasks, rather than patient contact, at this point resulted in participants feeling that the nurses prioritised these tasks over talking with them.

Participants who noted positive experiences when relating to the nurses emphasised the fact that these nurses had taken time to spend with them, and in some cases had spent time listening to them. For the participants, these contacts were described as single events. The fact that such single contacts were memorable implies that they stood out from the usual order of things. These contacts were notable not for the particular clinical expertise that the nurse brought to the situation, but for the fact that the nurse made time to be with the participant. Through their narratives, participants implied that these contacts made them feel cared for.

In response to their expectation of help not being met, participants developed strategies to support each other. Supporting each other necessitated the development of relationships in which participants felt comfortable to disclose personal issues. Thus, participants experienced the rapid development of close relationships with other patients. This closeness, whilst facilitating support, was also felt by some participants to leave them open to emotional harm. Managing the emotional impact of these relationships was a central concern for several participants. Participants who had previous multiple admissions to the acute ward had experienced the transient, yet intense, nature of these relationships. Their desire to avoid getting hurt resulted in

their relationships remaining on a superficial level, or in their withdrawal from this form of contact. For those who had no previous experience on the ward, who expressed feelings of vulnerability arising from their lack of knowledge of the ward routine and the system, the situation was conducive to the development of intense relationships with one another. Intense relationships, however, were not formed for the sole purpose of discussing personal issues; for some, it was the development of a connection with other people that was supportive. No matter what the level of personal disclosure within the relationships between patients, because these relationships were formed to fulfil the needs of the patients, the discharge of one of the parties, whether actual or anticipated, had an emotional impact on the other.

For this mutual support to occur it seems that it was necessary to have a space that was patient dominated. This was provided by the smoking room. As Goffman (1961) found in his study of life in an asylum, the patients were able to interact freely in what he termed '*free space*', geographical locations where the patients went unseen by the nurses. The smoke room seemed to represent such a free space, and it is perhaps because it was away from the nursing gaze that it provided the opportunity for the patients to offer each other support (Skorpen *et al*, 2008).

### 9.2.3 *Safety*

Participants also expected to be safe on the acute ward. Once again, their expectations were not matched by their experiences on the ward. Whilst participants experienced the ward as providing them with a sense of refuge from the stresses of life outside, when it came to relying on the nurses to protect them from the other patients they often felt unsafe. Thus, as with participants' expectations that the nurses would provide them with the help they wanted, so their expectations that the nurses would protect them from the threat of the other patients were unfulfilled.

The protection that participants experienced by virtue of being removed from the stresses of having to manage life outside the ward was perceived as one of the benefits of being on the acute ward; it gave them time to reflect and gather themselves together.

However, this sense of being completely safe was short-lived as the participants mixed with other patients. A feeling of vulnerability arose from the participants' expectations that people with mental health problems would behave in an unpredictable and perhaps aggressive manner. In assessing the risk posed by other patients, participants appear to be drawing on a discourse that links mental health problems with aggressive behaviour; such a discourse is often visible within the media's portrayal of people with mental health problems (Angermeyer & Schulze, 2001; Anderson, 2003). By applying this discourse to the rest of the patient group and not themselves, it is evident that the participants draw on stereotypes to replace knowledge about the other patients, thus facilitating the application of the discourse of mental illness and aggression.

In response to the feeling that they were unsafe, participants developed strategies to deal with being on the ward. As they gained experience of the ward, participants carried out their own risk assessments, enabling them to differentiate between people who should be avoided and people with whom it was safe to spend time. On this basis they developed strategies such as avoiding particular patients, or removing themselves from situations in which tension was escalating, in order to remain safe.

A further strategy that was widely used was to take refuge in a place that felt safe. This place of refuge was often the participant's bed space, with the curtain being pulled round the bed to give a sense of additional safety. However, this offered little real protection in the event of an act of aggression. The act of taking refuge also had implications for the participants' ability to get help, as it rendered them invisible to the nurses. It follows then that, because patients were expected to seek the nurses out if they wanted help, those who felt particularly threatened by the ward environment and spent a lot of time on their beds in order to feel safe, could find themselves isolated from any help that was on offer from the nurses.

Based on their knowledge of the available resources, participants made judgements about how the nurses dealt with aggressive situations. When the nurses did not deal with aggressive patients in the manner that the participants expected, the participants felt more vulnerable.



The dissonance between participants' and nurses' perception of when a situation required de-escalation, left participants feeling vulnerable. Participants described situations when they felt that aggressive behaviour was overlooked or allowed to spiral by the nurses. This may be the consequence of a ward culture where an increased level of aggression/tension has become the norm, resulting in the nurses' increased tolerance of aggressive behaviour. The development of such tolerance would lead to dissonance between the nurses' and participants' perceptions of what constitutes aggression.

A further cause of participants feeling unsafe was their perception that the male staff were more capable of keeping them safe than the female staff. Participants worried about their safety when there were no male staff on the ward. This perception of the male staff as more able to keep them safe was supported by participants' observations that the male staff on the ward were required to attend aggressive incidents when they occurred elsewhere in the hospital. Thus, it is not only the participants, but also those in charge of developing systems and protocols within the hospital, that draw on gender discourses with regard to management of aggression.

#### *9.2.4 Power*

Participants showed awareness of power relations on the ward, using this knowledge to inform their actions. Their knowledge that the psychiatrist had the power to detain and treat under the Mental Health Act led them to perceive him as the most powerful member of the ward staff team.

Despite his position as most powerful within the staff team, the psychiatrist was distant from the ward environment; for instance, only attending the ward to see particular patients, or to hold ward rounds. The data suggest that participants perceived that, in order to make decisions about their care, the psychiatrist needed to know what was going on with the patients on the ward. To this end, the nurses were perceived as the psychiatrist's agents, carrying out observations and reporting to him so that he could make his decisions. These perceptions resonate with Foucault's (1977) description of the panoptic mechanism; a disciplinary mechanism where the observations of those further down the hierarchy (in this instance, the nurses) provide the individual at the apex of the hierarchy (the psychiatrist) with the knowledge

required for him/her to retain his/her status as most powerful. The process of observation exerts its power on the observed through their knowledge that they are being watched and their inability to know when the gaze is upon them. In this way the observed act as if they are constantly being watched, modifying their behaviour in accordance with the power relations in which they are ensnared. As such, the data show that, in response to feeling that they were constantly being observed, the participants developed strategies to deflect this gaze by controlling their self-presentation and conforming to their concept of the good patient.

Thus, knowing the hierarchy of power relations within the staff team on the ward performed an important function for the participants. It allowed them to conceptualise how the actions of the nurses and medical staff fitted together and impacted on them, the patient. This enabled participants to understand how to influence the psychiatrist's decisions, as they perceived these as being premised upon the observations and reports of the nurses.

Participants also described a tension between them and the nurses that they referred to as 'them and us'. This tension was rooted in the patterns of relating between participants and nurses. Participants expected to experience a relationship that they referred to as the nurse-patient relationship. Their expectations of such a relationship were that it would be focussed on their needs, and that they would feel cared for. The lack of opportunity to develop such relationships, and in some cases the experience of the nurses actions as disrespectful, created an antipathy toward the nurses, as participants felt unsupported and disappointed. Within such relationships, participants refer to their understanding of the power relations between them and the nurses/medics in terms of their credibility as members of society. The awareness that society attributes greater credibility to nurses and medics than it does to people labelled as mentally ill, created divisions between the participants and ward team.

Three strands emerge from within the thematic data summarised above, and these will be discussed in the remainder of this section. These strands work across the boundaries of the material presented in Chapters Five to Seven, uniting the experience of the participants. Firstly, the dissonance experienced between participants' expectations of admission to the acute ward, and the actual experience of being a

patient there. The second strand is the participants' expectation that they will experience a particular form of nurse-patient relationship. The final strand is the strategic activity that the participants undertake to enable them to deal with their situation as a patient on the acute ward.

#### *9.2.5 Unfulfilled expectations: Experiencing dissonance*

Participants' experiences were characterised by a dissonance between their expectations of what the acute ward would offer, and their experience. Expectations arise from the application of a discourse model to a particular situation. The discourse model provides the individual with a framework to place over the new situation so that they have some idea of how it might go. Such discourse models draw on the discourses available to the person, as well as their previous experience of similar situations (Gee, 2005) (see section 3.3.3). Thus, whilst some participants had no previous experience of the acute ward, or perhaps even of being in hospital, they had expectations of the situation because they drew on discourses available in society about hospitals, nurses, health/illness as sources of knowledge.

The participants clearly expected that by going into hospital they would be helped to feel better. In their narratives they drew on discourses that designate hospitals as places that people go when they are ill, with the purpose of getting the care they require to get better. The data indicate that this expectation was strengthened when health professionals asked participants to become patients on the acute ward. There was an expectation that the acute ward would help them; something would happen on the ward that they could identify as a helping activity. However, through their narratives, participants made it clear that this did not happen. In some cases participants describe their disappointment at the lack of help they received on the acute ward.

A further aspect of the expectation of being in hospital was that the participants would be safe. As part of the hospital's role as a place where people are helped to get better, part of that help was envisaged as the provision of a safe environment. Whilst the hospital ward was experienced as a refuge from the outside world, participants described situations where they felt threatened whilst on the ward. Such threat arose from within the ward, in particular the actions of the other patients. Thus, participants

described dissonance between their expectation that the acute ward would keep them safe and their actual experience.

Much of the expectation expressed by the participants related to the role of the nurses on the acute ward. Participants expected the nurses to be caring, spending time with them and talking with them about their problems. They expected nursing activity to be focussed on the patients. A further element of the nurse's role was perceived as the ability to keep the participants safe from themselves and from others. Participants expected the nurses to be watchful over them, intervening appropriately where they posed a risk to themselves, or where they were threatened by others in the ward.

The data indicate that these expectations of the nurses' role were generally unmet. However, when these expectations were not fulfilled, many of the participants drew on narratives of staff shortages and increased paperwork as a means of excusing the nurses. Thus, whilst participants experienced dissonance when their expectations of the nurses were not met, this seemed to be uncomfortable, leading them to make excuses for the shortfalls rather than criticising the nurses. This discomfort when criticising the nurses may be an indication of a prevailing discourse that portrays nurses as angelic, fulfilling a calling to care for the sick; a discourse so powerful that it prohibits the telling of particular, critical, stories (Plummer, 1995).

The participants' expectations of the nurses' role illuminate their expectation of how nurse and patient would relate to each other. Through their narratives it becomes evident that the participants expected to experience a particular kind of relationship with the nurses, identifiable by the presence of particular qualities of interaction. This relationship is referred to as the nurse-patient relationship. However, resonating with the findings of other research (cf. Altschul, 1972; Moyle, 2003; Cleary & Edwards, 1999), the participants in this study struggled to identify nurse-patient relationships that met with their expectations.

#### *9.2.6 The myth of the nurse-patient relationship*

The data in this study make explicit the participants' expectations that the nurse-patient relationship is central to the therapeutic potential of the acute ward. Through their narratives, it became clear that participants had a strong sense of what

constituted a nurse-patient relationship. Pivotal features were the giving of time by the nurse to the patient, talking to participants about how they felt, and listening to them.

It is notable, however, that the participants' concept of what constitutes the nurse-patient relationship was not illuminated through narratives identifying the presence of these features. Just as in the photographic negative, the importance of these elements was made visible through participants' narratives referring to their absence; participants' unfulfilled expectations were illuminating their conceptualisation of the nurse-patient relationship. Thus, it was clear that the participants did not experience the relationship with the nurses that they had expected, or that fulfilled their needs, findings that resonate with those in previous studies (cf Moyle, 2003; Altschul, 1972; Cleary & Edwards, 1999; Bray, 1999; Higgins *et al.*, 1999; Baker, 2002).

The elements identified by the participants as central features of the nurse-patient relationship resonate with those proposed by policy makers (Scottish Executive, 2006a) and nurse-theorists (cf Peplau, 1988; Altschul, 1997; Barker *et al.*, 1995). Thus, it would appear that both patients and professionals are aiming for the same goal: the development of nurse-patient relationships premised on the concept of working in partnership to meet the patient's needs. However, within the research literature focussed on nursing activity within an acute ward context, it is evident that nurses too struggle to identify such relationships within their work (cf Cleary & Edwards, 1999; Bray, 1999; Bee *et al.*, 2006).

The evidence would therefore suggest that both nurses and patients are describing a similar concept when describing the nurse-patient relationship. So, if both professional and lay discourse describes the nurse-patient relationship in similar terms, yet despite this, the experience of both parties is that the nurse-patient relationship in that form does not exist, it is perhaps necessary to look toward the context in which nurses and patients interact to understand why this might be.

The acute ward context is influenced by health and social policy pertaining to the treatment and control of people who are diagnosed as suffering from mental illness (see section 2.2). The focus of mental health policy is the management of the risk

posed by people diagnosed with mental illness (Laurance, 2003; Hannigan & Cutcliffe, 2002; Keen, 2003). Thus, the role of the acute ward is also focussed on risk management (Bower, 2005; Scottish Office, 1997; Scottish Executive, 2006b). Nursing activities aimed at risk management are therefore prioritised, and much nursing time is spent observing those patients who require high levels of observation (Dodds & Bowles, 2001; Kettles *et al*, 2004). This has two consequences. Firstly, the focus of mental health policy on risk management reduces the capacity of the nursing staff to focus on other nursing activities. Secondly, whilst being placed on high levels of observation offers the opportunity for the development of the nurse-patient relationship, this often does not occur (Bray, 1999; Scottish Executive, 2002). The participants in Fletcher's (1999) study experienced the nurses' actions whilst observing them as distancing and controlling. Thus, the policy context of the acute ward may actively diminish the opportunity to develop nurse-patient relationships in line with those described in nursing theory or research.

Mental health policy designates power to those representing the institution of psychiatry, and in particular to psychiatrists who have the power to detain and treat people under the auspices of the Mental Health Act. Because of its roots, and the evolution of nursing from within the asylums, nursing practice is inextricably linked to the practice of psychiatry, and therefore bound to psychiatry's position in relation to the mentally ill. The participants in this study perceived the nurses as acting on behalf of the psychiatrist, observing them and reporting these observations to him/her. In this way, the nurses became part of a panoptic mechanism as described by Foucault (1977) (see section 2.3.4bii), deriving power from the participants' sense that they were always being observed, yet never knowing when or what was reported. Authors such as Campbell (2000), as well as the participants in this study, express their constant awareness of the psychiatrist's ability to detain and treat under the Mental Health Act.

The interpretation of such observations is influenced by the status of those on the acute ward as mentally ill patients. When diagnosed as mentally ill, people experience stigma as they are designated as belonging outside the normative group. Such categorisation as a member of a stigmatised group leads to expectations of particular behaviours that reinforce the person's membership of that group (Goffman,

1963). As such, the behaviour of a patient on the acute ward would be interpreted from within a framework that identifies behaviours as symptoms of mental illness. Thus, behaviours that might be interpreted as 'normal' for someone without a label of mental illness run the risk of being misinterpreted in light of the person's diagnostic label. Such misinterpretation was a prominent feature of Robert's narratives, whilst Becky talked about the need to mask her symptoms in order to appear normal.

In an attempt to deal with the constant gaze of the powerful, patients manage their presentation so that they do not experience the ultimate sanction: treatment under a section of the Mental Health Act. It follows, therefore, that if patients experience the need to manage their presentation on the ward, they will be unable to engage in nurse-patient relationships that require them to expose themselves. Thus, the perception of the nurses as part of the panoptic mechanism creates distance between nurse and patient.

A further aspect of the acute ward context is the multiple demands on nursing time. The requirement that the nurses undertake many housekeeping and administrative tasks diminished the time available to spend with the participants, and gave the impression that the nurses were too busy to talk. This demand on nurses' time has been highlighted in several studies as reducing nurses' contact time with patients (Bee *et al*, 2006; Whittington & McLaughlin, 2000; Ryrie *et al*, 1998; Clarke & Flannagan, 2003). Thus, the perception that the nurses are always busy does not create an environment where nurse-patient relationships can flourish.

Thus, wider issues pertaining to power and psychiatry may create a context within the acute ward in which it becomes impossible to develop the kind of nurse-patient relationships that is expected by the participants, and proposed within nursing theory. In particular, the oppositional conceptualisation of the role of the acute ward that is evident in mental health policy, and the participants' narratives: the former advocating a risk management role whilst the latter perceived the acute ward's role in therapeutic terms.

### 9.2.7 *Participants as strategists*

The data indicate that the participants were continually reflecting on, and developing strategies to deal with, their situation on the ward. The participants experienced a dissonance between their expectations and experience as patients on the ward with regard to the nurses' role in helping them and keeping them safe. Their experience of interacting with the nurses was characterised by a sense of distance. Participants described a situation where they were not getting the help they expected, they did not feel entirely safe, and they did not develop the relationships that they had expected to develop with the nursing staff. In response, the participants developed strategies to enable them to deal with the situation in which they found themselves.

The data give the sense that participants developed these strategies in order to survive the experience of being a patient on the acute ward. This is supported by the findings of Skorpen *et al* (2008) who studied patients in a Norwegian acute ward, concluding that the practices of resistance that their participants described improved their ability to survive being on the ward. Within this study, the development of strategies that enabled the participants to resist staff power was facilitated by what Goffman (1961: 205) termed '*free places*', somewhere on the ward where the patients were out of the gaze of the nurses; represented in this study by the smoke room. The nurses seldom entered the smoke room, and this enabled the patients to talk freely, offering each other support, and airing their views of the nurses. Participants developed relationships that resulted in them standing up to the nurses (see 7.5.3).

A further strategy of resistance was the participants' control of their self-presentation in response to their perception that the nurses were constantly observing them. By masking their symptoms, or presenting themselves as 'good patients', the participants hoped that the nurses would report favourably (that is, in a manner that supported their ultimate aim of discharge from the ward) to the psychiatrist. In her autobiographical writing, Chamberlin (1999) expresses the idea that this strategy had added potency because the staff did not believe that she could exert such control.

Other strategies were developed to fill the void that was created when the participants found that their needs for help or safety were not being met. The development of relationships with other patients in order to gain support was narrated in such terms as



to leave little doubt as to the importance attached to such relationships (see section 5.5.2). Such a strategy was not without its pitfalls, as participants talked about feeling burdened by others' problems and the emotional impact of those they were close to being discharged. However, despite the possible negative implications, relationships with other patients were developed out of necessity.

The development of supportive relationships with other patients, and in particular the spending of time in the smoke room, may have alienated the nurses still further. It is possible that the nurses felt intimidated by the atmosphere in the smoke room, particularly if it was a place where the participants discussed their discontent, creating tension. Further, the nurses may have perceived the participants as self-reliant as they looked for support from each other to replace the support that they perceived was unavailable from the nurses. It is perhaps a sense that they were not needed that underpinned the nurse's comment that the patients didn't seem to want their company (see 4.3.1). Thus, the strategy that participants developed in order to fill void when they did not get the support they wanted from the nurses may have diminished still further the opportunity for them to gain such support. Coatsworth-Puspoky *et al* (2006) found evidence that would support this conclusion when they observed the process of developing detrimental nurse-patient relationships, noting that nurses and patients developed patterns of avoidance.

In response to their perception of the other patients as potentially threatening, participants developed their own risk assessments. Quirk *et al*, (2004) also identified this strategy in their examination of patients' strategies for managing risk. As in this study, these authors also identified the use of geographical location by participants as a strategy adopted to keep them safe. The participants in this study described the ability to retire to their bed area as a means of coping when they felt threatened by the ward atmosphere.

Thus, participants were constantly engaged in assessing their environment, and developing strategies to cope. These strategies were aimed at smoothing their passage through the acute ward, filling the gaps created by unmet needs, and resisting the power of the institution.

In summary, participants' experiences are characterised by unfulfilled expectations. Expectations of help, safety and the development of a particular form of nurse-patient relationship were unmet. In response, participants developed strategies to meet their needs for support, safety and control over their situation. The findings indicate that participants were involved in a constant sense-making process. They developed discourse models, drawing on the discourses available to them in order to make sense of what was happening in the ward environment. These discourse models allowed them to expect various things to happen in various situations, giving them a basis against which to judge their experience.

### **9.3 Methodological conclusions**

#### *9.3.1 Introduction*

In this section I will reflect upon the impact of the methodological choices in this study. I will consider the data collection method, access and recruitment strategies, data analysis and presentation.

#### *9.3.2 Data collection*

Unstructured interviews were used to collect the data in this study. The quantity and richness of the data were indicative of the success of this strategy in eliciting narratives. Beginning only with a broad statement, I used my counselling skills to help the participants develop their narratives. The breadth of the initial statement allowed participants to develop their narratives in the manner that felt most appropriate for them. This allowed participants to focus on issues that had salience for them, and often participants would return to particular issues during their interview emphasising their salience.

The unfocussed nature of the interviews generated a breadth of information that would not have been possible using a more structured approach. Whilst initially a narrative appeared to be about one particular issue, on analysis it often became apparent that it illuminated deeper issues that were present for the participant. A structured approach might have closed down these seemingly irrelevant narratives.

A further aspect of the unstructured nature of data collection was the manner in which it allowed participants to protect themselves from over-disclosure. By giving the control of the agenda to the participants, they were able to close down or avoid topics that were uncomfortable for them to discuss. As far as I am aware, none of the participants experienced the interviews as intrusive, and many talked positively about having had the opportunity to explore their experience.

### *9.3.3 Access and recruitment*

Recruitment of participants from the acute ward resulted in a sample of people with a mixture of diagnoses, ages, and numbers of admissions. The data therefore represent the experiences of a number of individuals in different personal situations.

I can only hypothesise that meeting potential participants whilst they were still on the ward benefited the study in two ways. Firstly, the attrition rate was low. In all, only two people who had stated they would take part, declined to be interviewed. A further participant was not available for second interview and did not make contact to rearrange the appointment. During the interviews, however, many of the participants referred to our meeting on the ward, and it was clear that the relationship was perceived as developing from there. It was perhaps this sense that they were already in relationship with me that made people less likely to drop out of the study. Secondly, this sense that the research relationship had begun to develop prior to the first interview may have helped participants to feel comfortable to narrate their experiences to me, creating a rich data set.

The ethical review board, and other professionals such as the police, indicated that they considered interviewing people with mental health problems at home to pose a risk to me as researcher. However, I did not experience a sense of threat during any of the interviews despite my anxiety prior to the first interview with Peter (see 4.4.5a). I was always conscious of the potential risks and used my knowledge gained as a Community Psychiatric Nurse to assess the risks posed on entering each situation. I continued with this strategy because I thought the potential benefits of interviewing people in their own homes would outweigh the potential risk to me as researcher. Again, I can only surmise that interviewing participants in their homes, where they were comfortable and relaxed, helped me to achieve such rich data.

#### 9.3.4 *Data analysis*

The data analysis method developed in this study was based on Gee's socio-linguistic theories about narrative. These concepts provided me with a structured framework from which to approach the analysis of the narratives. Gee's work is explicit as regards transcription and the identification of narratives, and this helped guide my work. However, the transcription of such large amounts of data using Gee's principles was incredibly time consuming as it is so detailed, and required intense listening for changes in intonation, pauses and other aspects of the participants' speech. The time consuming nature of re-transcribing the narratives in line with Gee's work led to the agreement with my supervisors that I would only fully re-transcribe the interviews for six participants (representing half the data set). For the others, re-transcription of relevant narrative sections was carried out.

Despite its time consuming nature, the use of Gee's transcription methods benefited the study as it formed a graphic representation of how participants had told their narratives. Using this alongside Gee's (1991) theories about how structure links with meaning, I felt that I could get closer to the intended meaning of the narrator.

A further feature of Gee's work is the identification of focus material within the narrative. Again, the identification of this material by listening for changes in pitch required intense listening. However, examination of the material did throw up ideas regarding the meaning of the narrative that I had not previously considered.

Finally, the attention that Gee focuses on the development of cohesion throughout a narrative was useful, particularly when considering the small narratives as part of the big narrative. When carrying out the analysis I became aware of how participants went back and forth between narratives, indicating the relevance of previous information, and the assumption that the listener had prior knowledge of a topic. This aspect of Gee's work made me examine the narratives at a line-by-line level that prevented me from reading the transcripts and assuming that I knew what the participant was talking about. The use of Gee's work as the basis of the analytic process therefore resulted in a detailed analysis of the narratives that focused on how

the structure created the meaning, enabling me to feel that I was more likely to have grasped the narrator's intended meaning.

#### *9.3.5 Presentation of the data*

The choice to present the data both holistically and thematically was informed by my desire to allow participants' whole experiences to speak to the audience, as well as offering my interpretation of the meaning of these experiences. The choice of poetry as the form of such holistic presentation was exciting, but also daunting. I did not consider myself a poet (and still don't). However, the forming of the poems from my analyses offered an opportunity for the, interpreted, voices of the participants to speak.

The development of the thematic presentation of the data has the benefit of drawing together the experiences of all of the participants so that the common experience can be identified. This allows particular aspects of the participants' experiences to be highlighted on the basis that they are shared with others. Thus, some aspects of the experience are given significance through having been identified as common experience.

Each of these modes of presentation allowed me to illuminate different aspects of the data. The holistic poetic representations are focussed on the individual experience and are an attempt to present this whilst maintaining its integrity. The presentation of data in thematic form allowed me to highlight the experiences that were shared by participants, creating a sense of a common experience.

### **9.4 Implications of the findings and contributions to the field of knowledge**

#### *9.4.1 Introduction*

The findings of this study illuminate the gap between the participants' expectations of the acute ward and their experience of being on the ward. This experience is inextricably linked to the participants' perceptions of an absent nurse-patient relationship. These findings have implications for nursing practice on the acute ward.

#### 9.4.2 *Implications for nursing practice*

The findings of this study indicate that the perceived absence of the nurse-patient relationship was central to the participants' experiences. Participants in this study expected to have a relationship with the nurses that they would experience as helpful, and that the nurses would approach them to talk and spend time with them. They also expected that the nurses would keep them safe, but perceived that the nurses did not recognise when they were feeling threatened. When these expectations were unmet the participants experienced feelings that the nurses did not care or were not interested in them; disappointment and frustration; feelings of vulnerability; and a sense of distance between themselves and the nurses. This resulted in negative evaluations of their stay on the ward.

These findings imply that nursing practice on the acute wards needs to focus on the relationship between nurses and patients. Nurses need to engage with patients, spend time with them, making themselves more available, and work collaboratively with them to facilitate the development of relationships that patients experience as helpful. Thus, the findings of this study support the findings reported in *Rights, Relationships and Recovery: The report of the national review of mental health nursing* (Scottish Executive, 2006a). The review advocated that nursing focus on the development of values-based nursing (see appendix 1).

These ideas are not new, indeed Peplau (1988) proposed the nurse-patient relationship as the conduit through which mental health nursing occurs. However, despite widespread acknowledgement of the pivotal role of the nurse-patient relationship within the mental health nursing literature, research findings indicate that nursing practice does not always meet these standards. Ward administration and risk management activities seem to have taken priority over spending time with patients (cf Whittington & McLaughlin, 2000; Bee *et al*, 2006). The findings of studies such as Dodds and Bowles (2001) suggest that a shift in the focus of nursing, from observations to making time for patients, can have benefits.

Such a shift in nursing focus is integral to the Tidal Model. Developed by Barker (2000) following research into what people need from psychiatric nurses conducted

by him and colleagues, the Tidal Model focuses the nurse's attention onto the patient's experience. As Cook *et al* (2005: 536) state,

*“The Tidal Model guides nurses’ practice in order to facilitate a high level of engagement with patients.”*

Person-centred, the model focuses on the patient's narratives as the basis for assessment, care planning and delivery. During their evaluation of the Tidal Model in a forensic unit in New Zealand, Cook *et al* (2005) found that it decreased the distance experienced in nurse-patient relationships through what they refer to as “*levelling*” (538), a change in the power dynamics between nurse and patient. This was achieved by the nurses working in partnership with patients, accepting them as active participants in their care. Another evaluation of the Tidal Model carried out in England (Gordon *et al*, 2005) used untoward incidents<sup>17</sup> as a measurement of the success of the model. Gordon *et al*'s (2005) findings indicate that the Tidal Model can reduce the occurrence of such events, leading them to conclude that implementation of the Tidal Model improves the therapeutic environment of the ward.

The evidence reviewed above, indicates that developing the ability to work collaboratively with patients, making them active partners in their care and thus engaging with their experiences can improve the relationships between nurses and patients. Gordon *et al*'s (2005) findings are congruent with those of Dodds and Bowles (2001) who found that, increasing the amount of time the nurses spent engaging with patients decreased the number of aggressive or untoward incidents that occurred on the ward.

Greater engagement with patients means better, and more open, communication. Participants were constantly trying to make sense of their environment, and in particular the nurses' actions. During this sense-making process they drew upon their knowledge and experience. Much of their knowledge was gained indirectly, rather than from the nurses' explanations of what they were doing. This sense-making activity was important because it influenced how the participants behaved on the

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<sup>17</sup> Untoward incidents were conceptualised as indicative of an anti-therapeutic ward environment. Such incidents were categorised as clinical incidents, security incidents, and violent/harassment/abuse (Gordon *et al*, 2005).

ward, for instance, being the ‘good’ patient for fear of what was being written about them. The development of the nurse-patient relationship as advocated above would facilitate openness about nursing practice as well the patients’ perceptions, and facilitate the development of understandings of nursing practice based on a more secure knowledge base.

Consideration of the implications of the findings of this study for nursing practice must also take into account the context in which nursing takes place. Listening to the voices of those who use health services is recognised by policy makers as a means of ensuring that services provide what patients need. The findings of this research state clearly what the participants needed to enable their experience to meet their expectations and needs. The acute ward is part of a mental health service the development of which is influenced by both national and local mental health policies. Whilst the national policies offer guidance, they do not prescribe how they should be implemented, this being left for local definition (Scottish Executive, 2006b). The interpretation of the national policies, and subsequent development of local level policies that are applied within the acute ward have implications for nursing practice. Changing nursing practice, therefore, requires the support of local policy that must be reviewed to ensure that it reflects any change in philosophy of care. Attempts to change the focus of nursing practice without consideration of the policies and procedures already in place within the ward can reduce the impact of any change (O’Donovan, 2007).

#### *9.4.3 Contributions to the field of acute care research*

The data in this study provide a detailed picture of what it is like to be a patient on an acute ward in Scotland from the perspective of the patient. The findings contribute to a body of research into acute care, and offer insights from the perspective of the patient. It is anticipated that the Scottish context of the research, and its methodology, add significance to the findings.

The policy context of acute care was anticipated to influence the patient experience. The policy and legal context of mental health services in Scotland differs from that in England, as well as other countries. During the literature review I identified a dearth of Scottish studies into acute care. The Scottish context of this study is therefore



significant because it addresses this gap in the literature. It is notable, however, that the findings of this study resonate with those of the body of international studies reviewed in Chapter Two. This points to a certain universality of the experience of being a patient in an acute ward regardless of the particular policy context in which it is situated.

However, despite the congruence of the findings with those of other studies, the findings of this study are significant because of the methodology. The use of narratives as data enabled participants to talk about their experiences in a form that is familiar to them, the story, using their own language. The depth of the data indicates that participants, despite having mental health problems, were able to articulate their experiences in narrative form. The use of narratives as the data also highlighted the continual sense-making activity, and strategising, of participants whilst patients on the acute ward. This process was evident in participants' narratives about the times in their admission when they were acutely ill, highlighting the capacity of the mental health patient to act autonomously.

The unstructured interviews used to gather data allowed participants to prioritise issues of particular salience to them, as opposed to being asked to talk about topics that the researcher perceived as important. Thus, the topics addressed in this study are indicative of the pertinence of these issues to the participants' experience. The holistic approach to data analysis, focussing on how the participants told their stories in order to understand the messages they were trying to convey, and the checking of my interpretations of the first interview with the participants, guided my interpretations so that they would represent as closely as possible, the intended meanings of the participants.

## **9.5 Limitations**

The theoretical perspective and research design place particular limitations on the generalisability of the findings of this study. Firstly, this study is about 'experience': the experience of people who have been patients on an acute ward. Within this study, experience is theorised as being the product of beliefs, values, previous experience, attitudes, knowledge and other personal variables. These factors underpin the

individual's interpretive process as he or she tries to make sense of the situations in which he/she finds him/her self. Thus, the same situation is interpreted differently by different individuals as they draw on different experiences, beliefs and so forth. However, the findings indicate that although there were differences between the participants' experiences, there were also similarities. These similarities represent a shared or common experience. It can therefore be assumed that the participants' experiences will have commonalities with other patients on acute wards. This means the findings can be used to sensitise practitioners to the possible experience of others, whilst not being assumed to be directly transferable.

Secondly, narratives are conceptualised as co-constructed and socially and historically situated. Thus, the data, in the form of narratives, is conceptualised as constructed between researcher and participant, within a particular social and historical context. It follows, therefore, that the data achieved is not replicable by another researcher or in another social or historical context.

Finally, the sampling method and sample size place limitations on the generalisability of the findings. The sample size in this study was limited by the practicalities of dealing with large amounts of narrative data. The self-selecting nature of the sample means that the findings are not representative of the general population of psychiatric patients (such as might be assumed by the use of a randomisation strategy). The recruitment of the participants from a single acute ward, rather than a number of different wards, means that the experience represented within the data pertains to one particular ward with its particular socio-cultural context.

Taking into account the above discussion, the findings in this study are therefore considered to represent a snapshot of participants' experiences of being a patient on a particular acute psychiatric in-patient ward in Scotland. The value of such data is not in its ability to 'tell us how it is', but to *sensitise* the reader to the issues that are presented within the participants' narratives of their experience.

## **9.6 Recommendations for future research**

This study offers a broad base from which a number of research strands might be developed. Firstly, the dissonance between the participants' conceptualisation and experience of the nurse-patient relationship requires further exploration from both patient and nurse perspective: Why does such dissonance exist? Is it possible for nurses to fulfil the ideal of the nurse-patient relationship as conceptualised by patients?

Further, a variety of focussed studies examining the impact of specific variables on patient experience might be developed in order to yield specific information to facilitate the development of effective services. Such studies might focus on patient experience in relation to different diagnoses; gender; age; compulsory or voluntary admission; or whether or not the individual has previous admissions all of which might be hypothesised to influence the individual's experience of being a patient on an acute ward.

Finally, within the field of health services research the explication of the patient experience is gaining increasing importance. The research methods used in this study facilitated the exploration of patient experience, and would be applicable to the exploration of patient experience in other clinical areas. There is also scope to use these methods to study individuals' experiences of a number of phenomena both within and outwith the field of health research.

## **9.7 Summary**

In this chapter I have presented my conclusions based on the findings presented in Chapters Five to Eight. The methodology used facilitated the gathering of rich data. Detailed analysis generated a detailed picture of the phenomenon studied, the experience of being a patient on an acute psychiatric inpatient ward in Scotland. The presentation of the data in both holistic and thematic form gives the reader access to the unique and the common experiences of participants.

From the findings I drew the main conclusion that the experience of the participants is inextricably bound up with the absence of the nurse-patient relationship that they had

expected. The absence of this relationship resulted in participants describing their experience in terms of unfulfilled expectations of help and safety on the ward. This experience was inscribed with power relations.

I also concluded that the participants were actively involved in reflecting on their situation and developing strategies to enable them to tolerate being on the ward. The strategies discussed by the participants were developed in direct response to the dissonance between their expectations and experiences of being a patient on the acute ward.

These findings have implications for nurses, and for local policy development. They can sensitise nurses to the patient's experience, making them more aware of the impact of their own actions, as well as other facets of the ward environment. They may also facilitate the development of local policy in line with the needs of patients. With regards to national policy, the findings are supportive of the proposal within *Rights, Relationships and Recovery* (Scottish Executive, 2006a) that mental health nursing should become values-based (see appendix 1).

The fact that the findings of this study reflect the findings of previous studies, and particularly with regard to the nurse-patient relationship, is unsettling. Thus, the following quotation from Campbell (2000), a mental health system survivor, seems as relevant today as it did nearly a decade ago:

*“If the admission ward met my needs I would endure the process of admission and the absence of choice as necessary evils. But it is becoming clear that for myself and for many others the admission ward is in no way a satisfactory environment in which to recover mental health. The existing system is not sufficiently sophisticated, and those who operate it are not sensitive enough, for whatever reasons, to meet the real needs of the many individual people who are forced through it year after year.”*

Campbell, 2000: 58

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## Appendix 1: The values base for mental health Nursing

<b>Relationships</b>	<p>Putting positive working relationships supported by good communication skills at the heart of practice.</p> <p>Maximising time to build relationships and challenging systems that detract from this.</p> <p>Recognising when relationships are unhelpful and taking steps to address this.</p>
<b>Rights</b>	<p>Based on principles in legislation, safeguards and codes of conduct.</p>
<b>Respect</b>	<p>For diversity of values and placing the values of individual users at the centre of practice.</p> <p>Listening to what people say and not basing practice on assumptions about what people need.</p> <p>Seeing the whole person and not just his or her symptoms.</p> <p>Seeing the person as the 'expert' in his or her experience.</p> <p>For the contribution of families and carers.</p> <p>For the contribution of other professionals and agencies.</p> <p>For the social context of people's lives.</p>
<b>Recovery</b>	<p>Promoting recovery and inspiring hope – building on people's strengths and aspirations.</p> <p>Increasing capacity and capability to maximise choice.</p>
<b>Reaching out</b>	<p>To make best use of resources available in the wider community.</p> <p>To other agencies involved in mental health care.</p> <p>Being proactive about opportunities for change and mobilising opportunities to work with others to bring about change.</p>
<b>Responsibility</b>	<p>At corporate, individual and shared levels to translate the vision and values into practice by evolving current models for practice and challenging and shaping institutional systems and procedures to accommodate this.</p>

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## **Appendix 2: Information Leaflet For Ward Staff**

***“A qualitative study of individuals’ experiences of life as a patient on an acute psychiatric inpatient ward in Scotland”***

### **INFORMATION FOR WARD STAFF**

This booklet contains general information about the study that I am carrying out as part of my PhD. It is hoped that it will answer many of your questions about the research, although if you have any other queries please do not hesitate to ask me (my contact details are on the back of the leaflet). I am also aware that patients may ask you about the research and hope that the information provided will help you answer their questions.

I would like to take this opportunity to thank you in anticipation of your support whilst I am around on the ward, and hope that my presence is not too great an inconvenience.

Regards

Rosie Stenhouse

## **1. Background to the study**

My work as a psychiatric nurse in the community, hospital and voluntary sectors aroused an interest in how people experience their mental health problems and the care that we give them. This interest, and my sense of the difficulty that people with mental health problems have in making themselves heard, led me to develop this study for the purposes of my PhD.

The study has gained approval from the xxxxxx Ethics Committee and from the R&D Department in NHS xxxx.

## **2. Aims of the study**

The study aims to gather stories of individuals' experiences of life as a patient on an acute in-patient ward. These will be analysed and the information will:

- ❖ Contribute to the development of a critical mass of qualitative research studies focussing on acute psychiatric care
- ❖ Contribute to the development of responsive services for people in psychiatric crisis in Scotland
- ❖ Increase the professionals' understanding of the experience of life on an acute psychiatric ward from the patient's point of view

## **3. Who will be included in the study?**

Anybody who has a stay on the acute ward can participate. People with all kinds of diagnoses, lengths of stay, lengths of illness, male and female and of any age can take part in the study.

## **4. Who cannot take part in the study?**

People who are on a section of the Criminal Justice Act or being treated under the Adults with Incapacity Act (2002) will not be able to take part in the study.

People who are clinically assessed as posing a substantial risk to the safety of the researcher will not be included.

## **5. Recruitment to the study**

I will liaise with the Charge Nurses on the ward to discuss which patients are eligible to take part in the study. I will talk to people who are eligible to take part about the study and ask them if they would agree to take part. I will not get them to sign a consent form at this point, and they will not be expected to tell me straight away whether they will take part. I will encourage people to think about what taking part in the study means for them, and for them to discuss this with someone they trust – family, staff, xxxx Advocacy – or to speak with me again, before making a decision. Taking part in the study is entirely Voluntary, and even once people have agreed to take part, they can withdraw their consent at any time without giving a reason.

When a person has said that they want to take part then I will discuss with them where they would like to be interviewed and what sort of days and times suit them. I will then send them an interview time when they are discharged.

## **6. Consent**

Participation in the study is entirely voluntary, and consent will be sought at a number of stages:

- ❖ Verbal consent will be gained when the person agrees that they are willing to take part.
- ❖ Formal consent will be gained at the beginning of the first interview where I will check through the consent form with the participant and we will both sign this prior to the interview beginning.
- ❖ Verbal consent will be gained and recorded at the beginning of the second interview.

The participant may withdraw their consent at any time during the study without the need to offer an explanation.

The study will have 12-15 participants.

## **7. Interviews and data collection**

The participants' stories will be collected using in-depth interviews. Each participant will be interviewed twice; two weeks after discharge and then a month later.

Interviews will take place in the participant's own home, or in a place where they feel comfortable to talk, for example, a voluntary group, day hospital or other service they use.

The interviews will be recorded and then transcribed for analysis.

## **8. Data protection issues**

All personal data will be stored in line with the requirements of the Data Protection Act.

Personal details will be kept separate from participants' interview data. All recordings of interviews and subsequent transcriptions will be given a code to protect participant confidentiality.

Recordings of interviews will be destroyed at the end of the study.

## **9. Confidentiality**

Participants will not be required to inform their consultant psychiatrist, CPN or other members of their support network of their participation in the study, although they can do so if they feel it will be beneficial for them.

I will not inform anyone within the participant's support network unless they ask me to do so. However, if I have serious concerns about a person's health when interviewed I am obliged to inform the person's key worker, consultant or GP. Nobody will be informed about a person's participation in the study without discussing it with them first.

## **10. Anonymity**

All attempts will be made to hide the identity of the participants in the reports, thesis, journal articles and conference papers which will stem from the study.

Participants will be given pseudonyms, and some changes will be made to personal details to minimise identification. All quotations will be attributed to the pseudonyms.

## **11. Support for participants**

It is recognised that talking about their experiences of being on the ward might stir up issues that people want to talk to someone about after the interviews. At the end of each interview, all participants will be given a sheet with some contact information of local projects that can provide support. They will also be encouraged to use their existing support network for support if they feel able to.

Participants will also be able to contact me if they feel they need to. Each participant will have my contact number on the *Participant Information Booklet* they are given at our initial discussions about the study.

## **12. Timescale of the study**

The data collection stage (this stage) will be carried out between now and December 2006. I will then analyse all the stories over the following months, before spending approximately the next year writing up my thesis and producing reports of the research. The study will end in September 2008 (or sooner depending on how quickly I get it written up).

## **13. Dissemination of findings**

The findings of the study will be disseminated through the production of journal articles, speaking at seminars and conferences, and through my PhD thesis.

I will present a seminar for staff at xxxxxxxx/mental health staff within NHS xxxxx.

I will also produce a short report for people who took part in the study, and all those who are interested.

## **14. Researcher profile and contact details**

After graduating as a mental health nurse in 1992, I have worked in hospital and community settings, as well as the voluntary sector. Throughout these experiences



my working practice has focussed increasingly on developing a greater sense of partnership with those with mental health problems with whom I have worked.

Since 2002 I have been involved as a lecturer in Nursing Studies at the University of Edinburgh. Over that time I have gained my Masters by Research, and I am now a full time PhD student within Nursing Studies.

**Contact Details:**

Rosie Stenhouse  
PhD student  
Nursing Studies  
School of Health in Social Science  
University of Edinburgh  
Medical School  
Teviot Place  
Edinburgh  
EH8 9AG

Tel: 0131 650 3897 or 07737 968235  
Email: R.C.Stenhouse@sms.ed.ac.uk

## **Appendix 3: Information Leaflet For Participants**

“A qualitative study of individuals’ experiences of life as a patient on an acute psychiatric in-patient ward in Scotland”

*A research study to find out about people’s experiences of staying on an acute psychiatric in-patient ward.*

I would like to invite you to take part in this research study. Before you decide if you want to take part it is important for you to understand the purpose of the research study and what it will involve. Please take time to read the following information carefully and discuss it with others if you want. You can ask me any questions you have about the information, or if you need to know more.

Thank you for taking time to read this.

---

### **What is the purpose of the research study?**

The study aims to understand what it is like to stay on an acute psychiatric ward. People who have been patients on the acute psychiatric ward will be asked to talk about their experience, because their views are important. The information from the research can help service providers and people who decide on what services are available to design services that fit the needs of people who use them. This information can also help nurses and others working in the wards understand what it is like to stay on an acute psychiatric ward, and use this knowledge to inform their work.

### **Who can take part?**

If you have been given this information sheet by your key nurse on the ward you can volunteer to take part in the study. Taking part is your choice, and is completely voluntary. I expect that I will interview between 12 and 15 patients in total.

Although you are getting information about the study while you are still in hospital, the interviews will not happen until you have been discharged from hospital. I will come and talk with you about the study when you are on the ward and ask you if you would like to take part. I will confirm that you still want to take part after you have been discharged from hospital.

If you want to talk to someone about taking part you can talk to me, or to xxxxxxxxxxxx Advocacy service in his drop-in session on a Tuesday on xxxxx Ward, or call xxxxxxxxxxxx.

### **What will happen if I decide to take part?**

If you decide to take part I will arrange to meet with you in a place where you feel comfortable to talk, for example at home or at a voluntary project if you go to one. I will ask you to tell me what it was like to stay on the acute ward, and you can tell me your story however you want. I will ask some questions about what you tell me, as in a conversation, but I will not come with a long list of questions. What I am interested in is what you want to tell me about your experience.

I want to meet with you the first time about two weeks after you are discharged from hospital, and then a month later. Depending on how much you want to tell me, the interview will last around about 1 to 1 ½ hours. You will be able to stop the interview at any time if you wish.

I will ask you to sign a consent form, stating that you have understood the information about the study and that you are happy to take part, before we start the first interview. However, your participation is entirely voluntary and you can decide not to continue with the research at any point without giving an explanation.

### **What happens to what I tell?**

To help me remember what you say I will tape-record the interview. All tapes will be stored safely and separate from any information which would identify you, and will be destroyed following completion of the study. I will listen to the recording and transcribe what is said so that I can try to understand your story. When I come to see you for the second interview I will check that I have understood your story and what is important to you.

I will be getting around 12-15 people's stories and will look at them all together to help me understand what it is like to stay on an acute ward. I will write a full report of the research and will also write articles for journals and present the findings at conferences.

In the reports of the study I might want to quote directly from what you have told me in the interviews. To protect your identity a pseudonym, instead of your real name, will be used in reports, articles and presentations that are made about the study. If you want, you can choose the name you would like as your pseudonym. I will also change some of the personal information about you so that you are not recognised, for example age, town or area where you stay.

As well as the full report, I will write a summary report that I will send to everyone who took part, and anyone else who is interested.

### **What are the possible disadvantages or risks of taking part?**

Talking about your experiences might make you feel upset or bring back uncomfortable memories. However, you should remember that you are free to tell your story in a way that feels comfortable for you, I will not push you to talk about anything you don't want to. I will be leaving a list of people you can contact if you feel you need to talk to someone about how you feel after the interview.

People can worry that what they say about their experiences on the acute ward might affect the care they get if they are re-admitted onto the ward. All steps will be taken to hide people's identities so that nobody can be recognised in the report. You may find it helpful for your key worker in the community, your support worker or another person involved in your care to know that you are taking part in the research. You don't have to tell anyone if you don't want to.

### **What are the possible advantages of taking part?**

People in other research projects have often found it useful to have the opportunity to talk about their experiences. Whilst the interview is not a therapy session, sometimes just having someone listen to what you have to say can feel good.

Taking part in something that will make a positive difference to the care that people receive can feel empowering. The findings of the study will be written up as a report but also as journal articles and presented at conferences in the aim of having the most impact possible.

### **What if I have a complaint about the research?**

If you wish to make a complaint about the research you can go through the usual NHS complaints procedure.

If you have been harmed due to someone's negligence there may be grounds for you to take legal action, but you might have to pay for this.

### **Will my taking part in the study be confidential?**

You may find it supportive to tell your key worker, GP or consultant that you are taking part in the study. I will not inform any of these people unless you ask me to do so. However, if I have any serious concerns about your health when interviewed then I am obliged to inform your key worker, consultant, or GP. Nobody will be informed about your participation without discussion with you first.

### **What will happen to the findings of the study?**

I will share the findings of the research study through writing reports, getting articles published in professional journals, and talking at conferences and seminars.

**Who is the researcher?**

I am a post-graduate student at the University of Edinburgh and I am doing this study as part of my work for Ph.D. My motivations for doing this study come from my experience of working as a qualified Mental Health Nurse in the hospital, community and in voluntary organisations. Through my work, and from reading the available research, I have found that it is difficult for people with mental health problems to be heard and have their views taken seriously, and that there is not much research that tells us what it is like to stay on an acute ward from the patient's point of view. The aim of this study is to help the voices of patient be heard and to shed light on what it is like to stay on an acute psychiatric ward as a patient.

**Who has reviewed this study?**

As a Ph.D. student I have three supervisors at the University of Edinburgh who are all experienced researchers. The role of these supervisors is to make sure that the study is well designed, and that I carry it out in a way that is respectful to participants.

The Local Research Ethics Committee has reviewed the research proposal and given permission for the study to go ahead.

Contacts for further information:

For further information about the study, or if you decide you want to take part, you can contact me, Rosie Stenhouse, on 07737 968235 or 0131 650 3897.

To talk to someone who is independent about any worries you have about participating in the research study you can speak to xxxxxxxx, an advocacy worker from xxxxAdvocacy Project. xxxx does drop-in sessions in xxxxxx Ward on Tuesdays, or you can call him on xxxxxxxxx.

If you choose to take part in the study you will be given a copy of this information sheet and the consent form to keep.

**Thank you for taking the time to read this.**

## **Appendix 4: Participant Consent Form**

### **A qualitative study of individuals' experiences of life as a patient on an acute psychiatric in-patient ward in Scotland**

#### **CONSENT FORM**

**Please read the statements below and tick as appropriate**

	Yes	No
The research study has been explained to me and I have had the opportunity to ask questions		
I have been given a copy of the information sheet		
I understand what is involved in taking part in the research study		
I agree to the interview being tape recorded and understand that the tapes will be held confidentially and stored securely		
I agree to the quotation of material from the interviews in any subsequent reports and understand that all attempts will be made to hide my identity through the use of pseudonyms and changing of other identifying information		
I understand that taking part in the study is voluntary and that I can withdraw my consent at any time without giving reasons		
I understand that taking part in the research does not affect my treatment or rights in relation to the mental health services		
I would like the researcher to inform my GP/ Consultant/ Key Worker of my participation in the research study		
I am willing to participate in this research study		

\_\_\_\_\_  
Name of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## **Appendix 5: Example Of Summary Transcript**

### **SUMMARY TRANSCRIPT OF FIRST INTERVIEW**

The aim of this summary transcript is to set out a very preliminary analysis of our first interview to give you a sense of what I picked up from your story. When reading your story I have identified a number of broad themes, for which I have briefly described the content, as I understand it. I hope that this gives you a sense of my understanding of your story, and we can use the next interview to discuss and expand on these as well as to correct any misunderstandings.

#### **This is not my first admission**

You identify yourself at the beginning of the interview as someone who has had a number of admissions to hospital, and this fact appears to have an influence on several parts of your story:

- You perceive that your experience of having been on the wards and day hospital a number of times means that you are less likely to maintain contact with people you meet on the wards unless you happen to bump into them at, for instance, the day hospital.
- Your previous experience of hospital had generated a fear for you that you would end up as a long stay patient, and this influenced your ability to relate to this group of patients; there was a sense that they would want to keep you there in the hospital. However, through the development of relationships with some of the long-term patients you met while in hospital this time you describe yourself as having “overcome” your fear, particularly with your realisation that they were happy to see you get better and leave the hospital.

#### **Being observed**

You identify that at one point during your admission you felt that everything you did was under scrutiny by the staff. This was an uncomfortable feeling and you state that it might also have to do with being ill, but you also identify a couple of strategies that you use to deal with this:

- You learn to “surf” your thoughts and gain control over what you present to the outside world through your speech and behaviour; you describe this as “instead of being completely open and transparent you then become more within yourself”.
- You also describe doing everything by the book as a means of protecting yourself against the sense of being constantly observed. You present as the ‘model’ patient so that nobody can get at you.

- Your reference to having to learn to take things “on the chin”, to “accept it and just take it” indicates a sense that if you are seen to react to a particular incident or event it will act against you, like a black mark against your name. This you identify as very hard to do, and you give an example of having to just accept somebody’s rude remark when in a group and offering to let the person have a go of your guitar.

### **Keeping safe**

In the interview you tell two stories about safety. The first is when another female patient threatens you with violence after you are discharged; she is then moved into your dormitory and this makes you feel unsafe. You describe yourself as wanting to go straight back out on pass again.

The second story relates to the man who behaved aggressively toward you when you offered to let him have a go on your guitar. You describe how the nurse was giving definite signals to you not to react to his comments, and your sense that what she was trying to indicate to you was that if you reacted you might be in danger of being assaulted by him:

“...he might have belted me one, that was what the nurse was trying to get through to me, it’s all very well standing up for rights and all the rest of it, but somebody might belt you one, it could have been him.”

In reading this I am drawn to the fact that the nurse is indicating that you might get hit if you react to the comments. I wonder if this also indicates the nurse’s implicit knowledge that she (the ward?) is unable to ensure your safety if you stand up for your right not to be verbally abused.

### **Shifting relationships**

During the interview you describe shifts in a number of relationships over the time of your stay in hospital: your relationship with staff, your relationship with other patients and the shift of the focus to relationships outwith the hospital.

- Your relationship with staff seems to develop over the period of your admission and you state that the staff were “eventually” very good to you, and that even now that you are not in hospital you maintain contact with them and that this is positive for you.
- You describe making friends with other patients when you first are admitted. However, if you remain on the ward when the person/people you are friendly with are discharged you don’t bother to make particular friends with others after that. However, during your admission the patient population on the acute ward was quite violent causing you to actively avoid them and spend increasing time with the nurses.
- You identify that as you get better you want to spend your energies on the relationships you have with other people outside hospital as these have greater meaning and longevity for you than the perhaps intense but short-lived relationships you have with fellow in-patients.



## **Appendix 6: Example of Re-Transcription Using Gee's Theories**

### **Initial transcription of narrative**

There's a lot of this that my parents were horrified when they came in. Then we have another....I'm a little bit jumbled up, but then we had another incident where another patient was admitted who took an instant, I don't know, attraction or whatever, to me. She was a young girl who obviously had severe problems and it was incredibly frightening. On this day Amanda and Alex weren't about – Amanda had gone home, Alex was away out on pass - and I was kind of on my own. Now this girl kind of stalked me, everywhere I was she would come and sit, she thought I was somebody else, so she kept saying, "You're so-and-so." And I kept saying, "No, I'm not." "Well, who are you then?" She was aggressive. I didn't know how to handle it at all. Every time she came I would sit for a few minutes and then I would move off or go back to my room.....but it did stress me out quite a lot and I felt quite frightened. However, the next day at the dinner table I was sitting opposite somebody and the person that was sitting opposite me moved and this person came – she'd been sitting somewhere else and then immediately came to the table and I thought, "Oh dear." You know, I could tell she'd moved to deliberately be in front of me and, "Don't lift your eyes." So I kept on eating and the next thing I knew, it didn't hit me but a fist right, about this (indicates distance from her head) from my head. "I just don't need this." Finished my meal, just went straight back to my room, by which time I was totally hysterical. At that time, one, about five, ten minutes later one of the staff came down and said, "I thought you were upset." And I said, "Well, yeah, I just can't handle that, I don't know how to handle that. She's been stalk....she's been, there's just been something, she's been on me" "You should have come and told us." I thought, "No, I'm sorry, you should have seen that, that's your job. I don't know what the situ....I can't, I don't, you know, this girl is following me." I just, and he said "you know, we were watching we could see" and I said "she was like that last night and aggressive and .." and he said "oh well we'll keep our eye on things." But at that stage I thought I can't stay in this place any longer, I've got enough to deal with without worrying about the dynamics of things that are going on in here.

## **Re-transcription of narrative based on Gee's (1991) theory**

### **Strophe 14**

#### **Stanza 40**

1. There's a lot of this that/ my parents were HORRIFIED/ when they CAME in.
2. Then we had another/ I mean this is a bit jumbled up
3. but then we had ANOTHER/ INCIDENT where
4. another patient was ADMITTED/ who took an INSTANT/ I don't know/  
ATTRACTION or whatever/ to me.
5. She was a YOUNG girl/ who obviously had SEVERE problems and
6. was incredibly FRIGHTENING.

#### **Stanza 41**

7. On this DAY Amanda and Alex weren't about / Amanda had gone HOME/ Alex  
was away out on PASS / and I was on my OWN.
8. And this girl kind of STALKED me
9. EVERYWHERE I was/ she would COME and sit
10. and she thought I was SOMEBODY ELSE/ so she KEPT SAYING, "You're so-  
and-so."
11. and I KEPT SAYING, "No, I'm not."
12. "Well, WHO are you then?" / She was AGGRESSIVE.

#### **Stanza 42**

13. I didn't know how to HANDLE it at all
14. so EVERY time she came /I would SIT for a few minutes
15. and then I would MOVE off /or go back to my ROOM
16. but it DISTRESSED me quite a lot/ and I was quite FRIGHTENED

#### **Stanza 43**

17. However, the NEXT day
18. at the DINNER table
19. I was sitting OPPOSITE somebody /and the person that was sitting OPPOSITE  
me/ MOVED
20. and this PERSON came
21. she'd been sitting SOMEWHERE ELSE
22. and then IMMEDIATELY came to the table

#### **Stanza 44**

23. and I thought, "Oh DEAR." Sh/ you know/ I could tell she'd moved to  
DELIBERATELY be in front of me and
24. "Don't LIFT your eyes."
25. So I kept on EATING and the next thing I knew
26. it didn't HIT me
27. but a FIST right/ about THIS (indicates distance from her head) from my face
28. "I just don't NEED this."
29. FINISHED my meal
30. just went straight back to my ROOM/ by which time I was totally  
HYSTERICAL

#### **Stanza 45**

31. At that TIME/ one/ about FIVE, TEN MINUTES later /one of the STAFF came  
down /and said, "I thought you were UPSET."
32. And I said/ "Well, yeah, I just CAN'T HANDLE that/ I don't know HOW TO  
HANDLE that.
33. I said "SHE'S been stalk/ she's BEEN,
34. there's just been SOMETHING/ she's been ON ME"

#### **Stanza 46**

35. "You should have come and TOLD us."

- 36. I thought, “NO, I’m sorry
- 37. you should have SEEN that/ that’s YOUR JOB.
- 38. I don’t know what the SITU/ I can’t, I don’t, you know/ this girl is FOLLOWING me.” I just,

**Stanza 47**

- 39. and he said “you know/ we were WATCHING her there/ we could SEE”
- 40. and I said “she was LIKE THAT last night /and AGGRESSIVE with me and all the rest of it”
- 41. and he said /“oh well /we’ll keep our EYE on things.”

**Stanza 48**

- 42. But at that STAGE I thought
- 43. I CAN’T STAY in this place any longer
- 44. I’ve got enough things to WORRY about/ without having to worry about the DYNAMICS of things that are going on in here.

**Stanza 49**

- 45. Em, so at that STAGE/ that must have BEEN em
- 46. I can’t REMEMBER what day it was,

## **Appendix 7: Example Of Focus Material**

### **Focus material**

#### **Strophe 14**

Stanza 40: horrified, came # another, incident # admitted, instant, attraction # young, severe  
# frightening

Stanza 41: day, hone, pass, own # stalked # everywhere, come # somebody else, kept saying  
# kept saying # who, aggressive

Stanza 42: handle # every, sit # move, room # distressed, frightened

Stanza 43: next # dinner # opposite, opposite, moved # person # somewhere else #  
immediately

Stanza 44: dear, deliberately # lift # eating # hit # fist, this # need # finished # room ,  
hysterical

Stanza 45: time, five, ten minutes, staff, upset # can't handle, how to handle # she's, been #  
something, on me

Stanza 46: told # no # seen, job # situ(ation), following

Stanza 47: watching, see # like that, aggressive # eye

Stanza 48: stage # can't stay # worry, dynamics

Stanza 49: stage, been # remember

#### **Images and themes:**

#### **Strophe 14**

- Intimidation: frightening, aggressive, stalked, frightened, deliberately, hit, fist
- Movement: move, everywhere, moved, somewhere else

## **Appendix 8: Example Of Analytic Notes**

### **Strophe 14**

Jill introduces the scenario at the beginning of the narrative (lines 01-05) telling the audience how she evaluated the situation, '*she was a young girl who obviously had severe problems and was incredibly frightening*' (lines 04-05). Here Jill's use of the term '*obviously*' (04) is meant to infer that it was discernable to the casual observer that the girl had problems, presumably from her behaviour. It may also be presented here because Jill's experience is that it was used as a mitigating factor in rationalising the behaviour of both the female patient and the staff.

In Stanza 41, Jill makes the fact that her friends from the ward were away for the day important by placing it at the beginning of the stanza so that what follows is read with this in mind. The relevance of this phrase to the story can be viewed as its inference that, without the support of her friends, Jill feels vulnerable. Jill describes the female patient's activity as '*stalking*' and her difficulty in knowing what to do about it results in her deciding on a course of action where she is constantly on the move in order to avoid engaging with this patient; '*I didn't know how to handle it at all, so every time she came, I would sit for a few minutes and then I would move off or go back to my room*' (12-14). The relevance of this image of movement back and forth through the ward area becomes clear in stanza 47 where Jill feels that the staff should have noticed that she was being followed by the female patient. The first three stanzas act as background information for the interpretation of the central incident in this narrative, the attempted assault of Jill by this patient in the dining room. Jill describes herself as '*totally hysterical*' (29) following the incident, yet quotes the staff member who came to find her in her room some time later as saying "'*I thought you were upset*'" (30). These terms infer that Jill perceived that the staff attributed a reduced level of emotional significance to the event than Jill herself did. This coheres with the rest of the narrative where it is inferred that the staff reaction to the situation was to minimise the sense of threat; '*we'll keep our eye on things*' (40). As a result, Jill appears to feel that she is left to sort it out herself '*I've got enough things to worry about without having to worry about the dynamics of things that are going on in here*' (43).